WHY?

The Robert Dziekanski Tragedy

BRAIDWOOD COMMISSION
ON THE DEATH OF ROBERT DZIEKANSKI

MAY 2010

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May 20, 2010

The Honourable Michael De Jong, Q.C.
Attorney General of British Columbia
Room 232, Parliament Building
PO Box 9044 Stn Prov Govt
Victoria, B.C. V8W 9E2

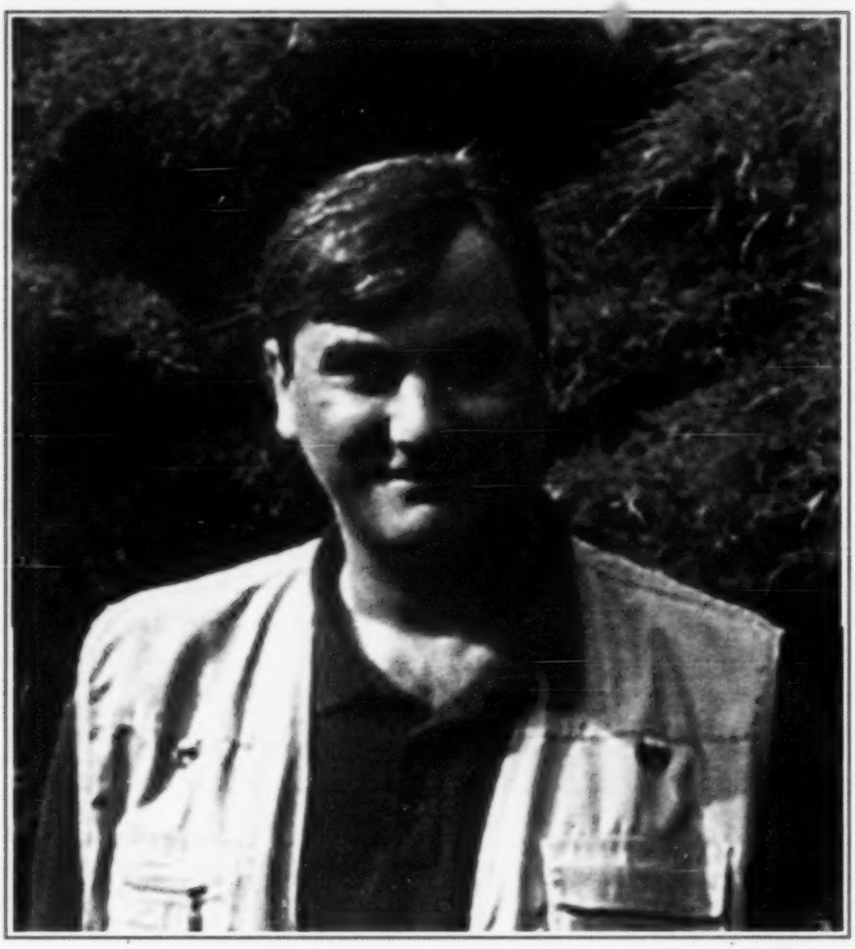
Dear Mr. Attorney:

Braidwood Hearing and Study Commission Report into the Death of Robert Dziekanski

I am pleased to deliver to you my report respecting the death of Robert Dziekanski at the Vancouver International Airport on October 14, 2007, and my recommendations respecting the handling of arriving international passengers at the Airport, as provided for in section 28 of the *Public Inquiry Act*, S.B.C. 2007, c. 9.

Yours very truly,

Thomas R. Braidwood, Q.C.
Commissioner



ROBERT DZIEKANSKI

Born: April 15, 1967, Bielawa, Poland
Died: Richmond, BC, Canada, October 14, 2007

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PART 1

EXECUTIVE SUMMARY AND RECOMMENDATIONS

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A. EXECUTIVE SUMMARY

Introduction

In October 2007, at the Vancouver International Airport, an officer of the Royal Canadian Mounted Police ("RCMP") used a conducted energy weapon against Mr. Robert Dziekanski, who, after being subdued and handcuffed, died within minutes. Public reaction to this incident was immediate and intense, and at a more general level, concern was expressed about the deployment and use of conducted energy weapons by policing bodies in British Columbia. In response to this public concern, the provincial government appointed me in February 2008 to conduct two separate inquiries under the *Public Inquiry Act*. The first inquiry report, entitled *Restoring Public Confidence: Restricting the Use of Conducted Energy Weapons in British Columbia*, included recommendations respecting the appropriate use of conducted energy weapons, including appropriate training and re-training. It was released on July 23, 2009.

The Commission of Inquiry

This second inquiry report deals with the death of Mr. Dziekanski. My Terms of Reference (set out in Appendix A) were:

- to conduct hearings, in or near the City of Vancouver, into the circumstances of and relating to Mr. Dziekanski's death;
- to make a complete report of the events and circumstances of and relating to Mr. Dziekanski's death, not limited to the actual cause of death;
- to make recommendations the commissioner considers necessary and appropriate; and
- to submit a report to the Attorney General on or before a date to be determined by the Attorney General in consultation with the Commissioner.

The Commission convened 61 days of evidentiary hearings at which 91 witnesses testified under oath or affirmation, followed by five days of closing oral submissions. Official participant status was granted to 16 individuals and organizations, all of whom were represented by counsel. Three of the 91 witnesses were senior employees of the Canada Border Services Agency and the Vancouver Airport Authority, who explained their policies, practices, and procedures respecting the handling of, and services provided to, arriving international passengers, especially those who do not speak English, and what changes have been made since October 2007.

Mr. Dziekanski's trip to Canada

Mr. Dziekanski was born in Poland in 1967, and lived his entire life there. After his mother immigrated to Canada and settled in Kamloops, BC, he made the decision in late 2007 to do so as well. He spoke only Polish, had never flown before and, in the days preceding his departure, grew increasingly anxious. His trip was rescheduled once, and on the night before his departure, he was panicky. Friends described him as shaking, vomiting, and clinging to a heat radiator in the apartment. However, once he began the drive to the airport he settled down. He flew to Frankfurt and then Vancouver, and his behaviour on both flights was uneventful.

Mr. Dziekanski's arrival in Vancouver and clearance to enter Canada

His flight arrived at Vancouver International Airport at about 3:15 p.m. on October 13, 2007, although he would not clear Canadian Immigration and exit the secure Customs Hall until 12:40 a.m. the next morning. As he approached the Primary Inspection Line, he was sweating profusely and had a disturbed look on his face. With some assistance from a Border Services officer, he was able to complete his Customs Declaration Card, and he proceeded through the Primary Inspection Line at 4:09 p.m. Because he was immigrating to Canada, he was required to proceed to Secondary Customs and Secondary Immigration. Because of the language barrier this was not explained to him, but the officer may have pointed behind her where he was to go.

For the next five-and-a-quarter hours, Mr. Dziekanski disappeared within the Customs Hall area. His mother, who drove from Kamloops with a friend to meet him, arrived at the Airport at about 1:20 p.m. When she realized that she would not be able to meet him at the luggage carousels in the secure Customs Hall (as she had promised him), she and her friend repeatedly sought assistance from a visitor information counsellor, customer service agents, and Border Services officers about a traveller from Poland who had never flown before and spoke no English. As time went by, she and her friend grew increasingly distressed, frustrated, and discouraged. A Border Services officer, after searching the Secondary Immigration area (but not the entire Customs Hall), told them that there was no way it would have taken this long for someone to get through Immigration. Without checking the computer, she also told them that in all certainty there was no landed immigrant from Poland there, and that they might as well go home. Some time after 10:00 p.m., Mr. Dziekanski's mother and her friend left the Airport and drove back to Kamloops.

At about 10:30 p.m. a different Border Services officer promptly processed Mr. Dziekanski through Secondary Customs and, realizing there was a language problem, escorted him to the Secondary Immigration office and then retrieved his two suitcases. Mr. Dziekanski was thirsty and appeared tired and frustrated, but was otherwise cooperative and compliant. An officer in Secondary Immigration found his immigration papers, paged Mr. Dziekanski's mother twice, then phoned her residence in Kamloops and left a message, and went into the public Meeting Area to try to locate his relatives. Using rudimentary Polish and hand gestures, she and another officer obtained enough information from Mr. Dziekanski to approve his application for immigration. She congratulated him on becoming a landed immigrant. When another officer found him still sitting in Secondary Immigration half an hour later, he escorted him out of the secure Customs Hall and wished him a good night.

Mr. Dziekanski's activities in the International Reception Lounge

Mr. Dziekanski entered the semi-secure International Reception Lounge at 12:40 a.m. The Airport's closed-circuit video showed him pushing his luggage cart into the public

Meeting Area, apparently looking around for someone. Members of the public and people working at the Airport used various words to describe his behaviours – unusual, upset, nervous, angry, distraught, and bizarre. He was sweating, appeared to be talking to himself, and at one point hit the glass doors with his hands in an attempt to get back into the lounge. He used his suitcases and a chair to form a barrier. Several people approached and talked to him, but could not communicate with him. None felt threatened by him, although several were reluctant to encroach on his "territory." Much of this interaction was caught on a bystander's video (the "Pritchard video"), which also showed Mr. Dziekanski smashing a small folding wooden table against a glass wall and throwing a computer on the floor, breaking it. However one characterizes his agitation and frustration, it was not directed at other people.

Several people who were in the public Meeting Area called 911 or the Airport's Operations Centre about the disturbance. At 1:23 a.m., the Operations Centre called the RCMP about an apparently intoxicated 40-year-old male in the International Reception Lounge throwing suitcases and chairs around. The Airport's own security personnel were also dispatched to the scene, but on their arrival they did not approach Mr. Dziekanski in accordance with their "observe and report" mandate. The four RCMP officers arrived at 1:28 a.m.

After the conducted energy weapon was deployed against Mr. Dziekanski, the Airport response coordinator took the prudent precautionary step of asking the Operations Centre to call an ambulance. When the coordinator was advised several minutes later that the ambulance had been upgraded to Code 3, he instructed the Operations Centre not to dispatch the Airport's Emergency Response Services, although Airport policy required it. He also did not arrange for an automated external defibrillator to be brought to the scene, as required by Airport policy.

The response of the RCMP, Richmond Fire-Rescue, and BC Ambulance Service

Corporal Robinson and Constables Bentley, Millington, and Rundel were in the RCMP's Airport sub-detachment when the call was received. Cst. Millington responded, and the other three officers went as well, all in separate cars. They testified that they had no discussions en route to the Airport. Notwithstanding an e-mail between two senior officers suggesting that the four officers decided en route that if Mr. Dziekanski did not comply they would use a conducted energy weapon against him, I am satisfied that the four officers did not develop any such plan.

As the four officers approached the swinging glass doors that separated the public Meeting Area from the International Reception Lounge, they saw Mr. Dziekanski. Their descriptions paint a fairly consistent picture of a man who was unkempt and sweating, breathing heavily, disoriented, agitated, perhaps emotionally disturbed, and with a wide-eyed, glazed look. He was calm and cooperative when the officers first engaged him, with his hands at his side. There was debris on the ground, but no sign of broken glass.

Cst. Bentley, assuming the role of contact officer, took an appropriate first step by saying, "Hi, how are you, sir? How's it going, bud?" Owing to the language barrier, Mr. Dziekanski did not respond. At that point, Cst. Millington unilaterally intervened as contact officer, making hand gestures for Mr. Dziekanski to calm down, asking for "passport" and "identification," and miming writing with a pen. Although his intervention was not warranted, I am satisfied that it was well-intentioned and was a reasonable way of establishing whom they were dealing with. The Pritchard video shows Mr. Dziekanski making a very tentative downward movement toward the nearby luggage, which I am satisfied was his attempt to comply with Cst. Millington's demand to retrieve his travel documents.

As Mr. Dziekanski bent down (at 3:37 on the Pritchard video), Cpl. Robinson stepped in and took charge. He said, "No. Stop" in a stern, authoritative voice, and made a pointing gesture with his arm. Mr. Dziekanski stopped going toward his luggage. According to the Pritchard video he returned to a normal upright stance, with his arms at his side, engaging in eye contact with the officers. In my view he was complying with Cpl. Robinson's direction. It was not necessary for Cpl. Robinson to intervene at all, and even if it was, given the circumstances it was an inappropriately aggressive reaction.

At 3:41, Mr. Dziekanski then threw up his arms, lowered his head and turned away from the officers, moving toward a nearby counter. As he did so, Cpl. Robinson moved closer behind him with his arm outstretched, pointing toward the counter. Mr. Dziekanski said, in translation (at 3:43): "Leave me alone. Leave me alone! Did you become stupid, *or* Have you gone insane? Why?" Although the officers described Mr. Dziekanski's behaviour as defiant or resistant, I disagree. He took this action on his own initiative out of frustration, not in response to a command from any of the officers. He had not been told to stay where he was, so in moving away he was not acting contrary to a direction or command. If Cpl. Robinson wanted Mr. Dziekanski to put his hands on the counter, I am not satisfied that Mr. Dziekanski understood any such direction. As Mr. Dziekanski moved toward the counter, Cpl. Robinson followed close behind, pointing toward the counter. When he did so, the video shows that Mr. Dziekanski did in fact move to the counter, which I interpret as him acting in compliance with Cpl. Robinson's direction.

Mr. Dziekanski reached the counter at 3:44, turned and faced Cpl. Robinson. At 3:45 Mr. Dziekanski shuffled backward a step, rotated to his right, and picked up a stapler off the counter. At 3:46 Cst. Bentley appeared to react to something he saw, and at 3:47 Cpl. Robinson pulled out his baton. The Pritchard video shows Mr. Dziekanski with his upper arms against his torso, but his lower arms and hands are not visible. At 3:49 he may have said, "Police, police." Cpl. Robinson raised his left arm and pointed at Mr. Dziekanski, and one hears the snap of Cst. Millington deploying the conducted energy weapon in probe mode. I am satisfied that after Mr. Dziekanski picked up the stapler, he held it in his right hand, in front of him, and at or below his chest level. He did not brandish the stapler by either placing it above his head or motioning with it in an aggressive manner toward any of the officers. Further, I have concluded that Mr. Dziekanski did not step toward one or more of the officers while clenching the stapler. Attempts by Cst. Rundel and Cst. Bentley, during their testimony, to clarify their statements to IHIT investigators and in their police notes were patently unbelievable after-the-fact rationalizations.

Cst. Millington and Cpl. Robinson gave three reasons for deploying the weapon: Mr. Dziekanski's combative nature or stance, his clenching the stapler in his raised fist, and his stepping toward the officers. They testified that they believed he intended to attack. In my view, Cst. Millington was not justified in deploying the weapon against Mr. Dziekanski, given the totality of the circumstances he was facing at the time. Similarly, Cpl. Robinson was not justified in instructing him to deploy the weapon. Further, I do not believe that either of these officers honestly perceived that Mr. Dziekanski was intending to attack them or the other officers. Neither officer carried out an appropriate reassessment of risk immediately before deployment of the weapon. They approached the incident as though responding to a barroom brawl and failed to shift gears when they realized that they were dealing with an obviously distraught traveller. I am equally critical of the policy and training paradigm that fosters such poor decision-making.

When the weapon was deployed, one probe lodged in Mr. Dziekanski's chest and the other in his shirt, which was flapping loosely against his body, causing the discharge of electrical current to be intermittent. During this six-second discharge, Mr. Dziekanski began screaming, with his arms flailing in front of him. He stumbled to his right, away from Cst. Millington, and fell to the floor. After a one-second break, Cst. Millington deployed the weapon a second time in probe mode, for five seconds. The current was again intermittent. Mr. Dziekanski was on the floor screaming, with his arms and hands held tightly against his chest, his body partially curled up, his legs thrashing, and his body moving around in a circular motion. In my view, the weapon's failure to immobilize Mr. Dziekanski during the first deployment was not a justification for deploying it a second time.

The other three officers then moved in, wrestled with Mr. Dziekanski, and eventually got his arms behind his back and handcuffed him. In my view, it was safe for these three officers to move in and restrain Mr. Dziekanski during the second deployment, and they acted unreasonably in not doing so then. During the struggle, Cst. Millington deployed the weapon a third time in probe mode. In my view, he did not adequately reassess the risk before deploying the weapon, and neither did Cpl. Robinson before ordering him to do so. I also am satisfied that during the struggle Cpl. Robinson applied force with his leg to Mr. Dziekanski's neck area when such force was not justified, given the totality of the circumstances he was facing at the time. Cst. Millington also deployed the weapon twice in push-stun mode (for nine and six seconds, respectively, with intermittent current) against Mr. Dziekanski's upper back shoulder area for pain compliance purposes, to persuade Mr. Dziekanski to let the officers pull his arms behind his back and handcuff him.

The initial claims by all four officers that they wrestled Mr. Dziekanski to the ground were untrue. In my view they were deliberate misrepresentations, made for the purpose of justifying their actions.

Within five to ten seconds after being handcuffed, Mr. Dziekanski stopped kicking his legs, and he lay motionlessly while breathing heavily. When Cst. Bentley observed Mr. Dziekanski go unconscious, he requested an ambulance. When he saw Mr. Dziekanski's face turn blue shortly thereafter, he realized that they were facing a medical emergency, and promptly and prudently upgraded the ambulance call to Code 3. The RCMP officers and an Airport employee placed Mr. Dziekanski, while still handcuffed, on his side in a modified recovery position, but some time later he returned to the face-down prone position. I accept the evidence of the Richmond Fire-Rescue firefighters that, when they arrived, none of the four RCMP officers were attending to or monitoring Mr. Dziekanski.

Cpl. Robinson refused the firefighters' request to have the handcuffs removed, saying that he had been violent. In my view, his refusal was unjustified. The firefighters determined that Mr. Dziekanski was unconscious, saw no evidence that he was breathing, and could not get a radial or carotid pulse. They were surprised that the Airport's Emergency Response Service was not on scene, as they always arrived before the firefighters.

When two basic life support paramedics arrived, they immediately saw that Mr. Dziekanski's face was bluish, i.e., cyanotic. After repeated requests, the handcuffs were removed. When Mr. Dziekanski was rolled onto his back, his lips and tongue were blue, he was not breathing, and he had no carotid pulse. Although the paramedic thought that Mr. Dziekanski was dead, he ordered oxygen and chest compressions. The automated external defibrillator advised "no shock," which meant there was no heart rhythm (i.e., asystole). Within two minutes, two advanced life support paramedics arrived. They commenced intravenous treatment and medications, and endotracheal intubation. After 20 minutes of resuscitation attempts, Mr. Dziekanski was pronounced dead.

The RCMP's Integrated Homicide Investigation Team ("IHIT") officers took control of the scene, and the four RCMP officers made their police notes and returned to the Airport sub-detachment. Later that morning they were interviewed by IHIT investigators. They all testified that there was never any discussion between or among them about what had happened at the Airport, before giving their statements to the IHIT investigators. Taking into account the officers' opportunity to discuss the incident, an understandable motivation to present an account that would justify their conduct, and the similarities in their post-incident statements, I concluded that they did discuss the incident among themselves before they were interviewed by the IHIT investigators. While the evidence does not justify a conclusion that they colluded to fabricate a story, I am satisfied that their discussions resulted in them giving surprisingly similar accounts of the incident that tended to misrepresent what had happened, and tended to portray Mr. Dziekanski's actions in an unfairly negative light and their own actions in an unfairly positive light.

I also concluded that when Cst. Millington completed the conducted energy weapon usage report, he consistently and deliberately misrepresented and overstated Mr. Dziekanski's behaviours and actions in a manner prejudicial to Mr. Dziekanski, and chose self-serving language for the purpose of justifying his actions.

The unprofessional manner in which Cst. Millington and Cpl. Robinson dealt with Mr. Dziekanski, and all four officers' less-than-forthright accounting for their conduct, have had repercussions that extend far beyond this one incident. Mr. Dziekanski's death appears to have galvanized public antipathy for the Force and its members. That is regrettable, because the most important weapon in the arsenal of the police is public support. This tragic case is, at its heart, the story of shameful conduct by a few officers. It ought not to reflect unfairly on the many thousands of other RCMP officers who have, through years of public service, protected our communities and earned a well-deserved reputation in doing so.

The cause of Mr. Dziekanski's death

I considered the testimony and written reports of 14 medical experts – forensic pathologists, cardiologists, emergency department physicians, psychiatrists, an epidemiologist, and an electrical engineer. Despite a consensus that Mr. Dziekanski suffered an electrical death (i.e., a fatal cardiac arrhythmia that caused cardiac arrest), there was considerable debate and disagreement among these experts as to the process by which that fatal arrhythmia developed.

Two contradictory scenarios emerged from the evidence about when Mr. Dziekanski died. The "continued breathing" scenario postulates that he was last observed breathing about two minutes before the Richmond firefighters arrived, which means that he continued to breathe for at least 10 minutes after the time when the handcuffs were applied. The "cyanosis" scenario postulates that the evidence of Mr. Dziekanski's face being blue about 75 seconds after being handcuffed means that this cyanotic condition (i.e., inadequate oxygenation of the blood) must have been developing for some time, most likely because of heart failure. This would mean that Mr. Dziekanski's heart stopped pumping during the preceding 50 seconds – after he stopped struggling and before his face turned blue. I concluded (for the reasons discussed in Part 7) that the cyanosis scenario is the more likely sequence of events. Consequently, Mr. Dziekanski most likely died at most 75 seconds after he was handcuffed and at most two minutes after the completion of the third probe-mode deployment of the conducted energy weapon.

The autopsy did not disclose an anatomical or toxicological cause of death, thus ruling out a heart attack, a chronic medical condition, a blunt trauma, or an internal injury. We will never know, with absolute certainty, what caused Mr. Dziekanski's death. The best we can do is draw inferences from the known facts, and reach conclusions about the most likely cause of death. The evidence gave rise to four possible causes of death:

- ***Pre-existing heart disease plus accumulated stress*** – it was suggested that Mr. Dziekanski's accumulated stress and agitation could have triggered a hyperadrenergic effect before the RCMP officers arrived, whereby his system was flooded with adrenaline and other catecholamines and that this reaction, coupled with his pre-existing medical condition, could have overwhelmed his heart, leading to cardiac arrest. I am not persuaded that this scenario adequately explains his death, for several reasons. I am not convinced that Mr. Dziekanski had alcoholic cardiomyopathy, that he was experiencing alcohol withdrawal, or that he was in a state of agitated delirium. In any event, these accumulated stresses and any pre-existing medical conditions did not cause, on their own, a fatal arrhythmia. When the four RCMP officers arrived, Mr. Dziekanski recognized them as such, engaged with them, and cooperated with their request for identification.
- ***Weapon-induced direct capture of Mr. Dziekanski's heart*** – although I am satisfied that the electrical current from a conducted energy weapon is capable of triggering ventricular fibrillation, I have concluded that it is unlikely to have happened in this case. The 70-second delay between the end of the third probe-mode deployment of the weapon and Mr. Dziekanski's lapse into unconsciousness is too long a time period. Also, it is not clear if the two probes were across the cardiac axis and, even if they were, it is not known whether they penetrated close enough to the heart for the electrical current to capture the heart.
- ***"Sudden death during restraint" and/or "excited delirium"*** – several medical experts testified about a phenomenon whereby a person exhibiting bizarre behaviour will sometimes die soon after being restrained, for no apparent reason. The person will typically act irrationally, be unaware of their surroundings, be hyperthermic, will often disrobe in public, be impervious to pain, and exhibit superhuman

strength. Almost always, the person will be intoxicated with an illicit stimulant such as cocaine and will have a history of serious mental illness. In my view, neither of these postulated conditions have any application to this case.

- ***The hyperadrenergic state arising from the weapon deployment and physical altercation*** – since the stress and fatigue that accumulated before, during, and after Mr. Dziekanski's trip to Canada, and any pre-existing medical condition, did not collectively trigger his cardiac arrest, did his subsequent interaction with the RCMP officers (i.e., multiple deployments of the conducted energy weapon and physical wrestling) do so? From my analysis of the chronology, I concluded that Mr. Dziekanski's interaction with the officers took 75 seconds, and he likely went into cardiac arrest within the next 25 seconds. I am satisfied that the hyperadrenergic response, which was significantly exacerbated by Mr. Dziekanski's interaction with the RCMP officers, is the most likely cause of his death. Acidosis may have played a part as well. It would defy common sense to conclude, from all the evidence, that the physical altercation exacerbated the hyperadrenergic state that led to Mr. Dziekanski's fatal cardiac arrhythmia, but that the multiple deployments of the conducted energy weapon played no part. It is beyond dispute that a single five-second deployment of the weapon causes intense, extreme pain, as well as emotional trauma. The evidence does not allow me to conclude, with mathematical exactitude, how much the weapon and the physical altercation contributed to the hyperadrenergic state that led, ultimately, to Mr. Dziekanski's death. Unquestionably, they both contributed substantially to that tragic result. I consider it a reasonable inference to be drawn from all the evidence that the multiple deployments of the conducted energy weapon played a more prominent role.

The RCMP's media response to Mr. Dziekanski's death

The RCMP's IHIT took charge of the investigation, to determine whether any criminal charges should be laid arising out of Mr. Dziekanski's death. During the three days immediately following the incident, a bilingual sergeant spoke to the media and issued news releases about the incident. It is not in dispute that some of the RCMP's public disclosures about the Dziekanski incident, during the early stages of the criminal investigation, were factually inaccurate. When the RCMP became aware of these inaccuracies, the officer in charge of IHIT decided not to correct them, choosing instead to limit public statements to matters of process, not evidence. This poorly managed media response to Mr. Dziekanski's death was widely reported and generated negative comment in the media, culminating in an official RCMP apology. In my view, three factors were principally responsible for this regrettable media response:

- ***The rush to publish*** – a well-intentioned desire to inform the public about what had happened at the Airport pre-empted the equally important goal of accuracy. In hindsight, it would have been preferable to avoid any detailed discussion of the circumstances at that early stage in the investigation.
- ***The decision not to correct inaccuracies*** – the factual inaccuracies, consistently self-serving, painted Mr. Dziekanski in an unfairly negative, and the officers in an unfairly positive, light. Although the officer in charge of IHIT erred in not correcting the inaccuracies right away, I am satisfied that his error was, at most, an error in judgement. My principal concern is that if there was RCMP-generated information in the public domain that might influence potential witnesses, better that it be *accurate* information.
- ***The conflict of interest*** – if this had been a brawl outside a bar involving two intoxicated patrons, initial inaccuracies respecting one patron's behaviour or the number of times a weapon was fired would have been understood for what they were – initial findings that were subject to change as more information became available. The extraordinarily different reaction in this case occurred because this was a police-related death, with the RCMP assuming responsibility for conducting the criminal investigation flowing from it and for releasing information to the media and public about the incident and the investigation. It was a case of the police investigating themselves, and many members of the public are understandably suspicious of such investigations, no matter how thorough and impartial they turn out to be. If the criminal investigation had been conducted by a body at arm's length from the RCMP, that body would have been, and would have been perceived by the public to have been, impartial. The public would have been much more likely to have accepted without suspicion what such an impartial body said about the incident.

Recent changes at Vancouver International Airport

Canada Border Services Agency (CBSA)

It is appalling that Mr. Dziekanski could have been cleared through CBSA's Primary Inspection Line efficiently, only to disappear within the cavernous Customs Hall for over five hours. I recommended that Border Services officers explain to each arriving international passenger, in a manner the passenger understands, where he or she must go and how to get there. I also recommended that CBSA implement a single integrated database system for tracking each arriving international passenger's progress through Secondary Customs and Secondary Immigration, and issue an alert if a passenger does not reach the next location within a predetermined period of time.

CBSA should do more to assist greeters who ask for help while awaiting arriving international passengers. Although federal legislation restricts passenger information that can be disclosed to greeters, an exception should be made in the case of greeters who are sponsoring immigrants. Border Services officers should be required to determine whether the passenger a greeter is concerned about has crossed the Primary Inspection Line and to make an entry in that passenger's computer file about the greeter.

CBSA officers should receive training, regularly updated, on what interpreter services are available to them and to arriving international passengers, and how to access such services. In addition, CBSA should provide its officers with adequate resources to ensure that arriving international passengers know where they have to go within the Customs Hall and how to get there, know what is being asked of them, know if a greeter has attempted to contact them, and are assisted in their own language if they appear to be confused or distressed.

Vancouver Airport Authority

I am impressed with the Airport Authority's prompt and thorough review of its customer care services that it undertook following Mr. Dziekanski's death and the extensive changes that it has implemented, such as its International Arrivals Response Coordinator and Customs Hall Rover positions.

I unreservedly endorse the Airport Authority's attempt to introduce a Passenger Record of Entry and Exit system, and I urge implementation of the single integrated database system I recommended earlier. A digital Passenger Information Board should be installed in the Customs Hall, on which waiting greeters can place their name so that arriving passengers are aware of their presence. Also, the Airport Authority's customer service agents should be permitted to page from the public Meeting Area into the Customs Hall, and *vice versa*.

The Airport's contracted security patrollers are often the first responders to medical and behavioural crises, and their current "observe and report" mandate is inadequate at such a large, busy, and prestigious international airport. The travelling public would be much better served if security patrollers received training in first aid and verbal de-escalation techniques, and were expected to actively assist members of the public who are in distress.

I commend the Airport Authority for recent improvements to its emergency and medical response services. However, one other medical emergency issue warrants attention. The Dziekanski case is an example of a safety and security incident evolving into a police use-of-force incident and then evolving further into a medical emergency incident. There was confusion about who was responsible for what in such situations. The travelling public would be well served if the Vancouver Airport Authority, RCMP, Richmond Fire-Rescue, and BC Ambulance Service worked together in formulating a plan of action for dealing with such incidents.

Two-year review

Finally, I recommended that within two years of this report being made public, the provincial Minister of Public Safety and Solicitor General report publicly on the extent to which the federal government and the Vancouver Airport Authority have implemented these recommendations.

Postscript — police investigating themselves

The Dziekanski incident was a case of the police investigating themselves, which gives rise to legitimate concerns about conflict of interest. The perception that investigators will allow loyalty to fellow officers to interfere with the impartial investigative process, even if not justified in a given case, can lead to public distrust and an undermining of public confidence in the police.

I agree with the Davies Commission of Inquiry's 2009 recommendation that British Columbia should establish a civilian-based investigative body, modelled on Ontario's Special Investigations Unit, to investigate all police-related incidents to determine whether criminal charges should be laid against a police officer. I recommended that this investigative body:

- should have province-wide jurisdiction (i.e., municipal police departments and the RCMP);
- should investigate police-related incidents involving death, serious harm, and possible contraventions of any *Criminal Code* provision, as well as the possible contravention of other federal and provincial statutes that, if the incident were investigated by a police officer, might in the minds of reasonable, informed members of the public undermine confidence in the police; and
- should be entirely civilian – no member should have served anywhere in Canada as a police officer. However during the initial five-year transitional period, former police officers may be employed, subject to several restrictions.

This civilian investigative body's investigators should have the status of police officers. They would become the lead investigative agency, take control of the incident scene, question witnesses, and be in charge of forensic analyses. A special prosecutor appointed under the *Crown Counsel Act* would make charge assessment decisions and, if criminal charges were approved, would conduct the prosecution.

B. SUMMARY OF RECOMMENDATIONS

CANADA BORDER SERVICES AGENCY

Processing passengers

1. I recommend that the Attorney General urge the federal Minister of Public Safety:

- To require that Border Services officers at Vancouver International Airport's Primary Inspection Line explain to each arriving international passenger, in a manner the passenger understands, whether the passenger is required to proceed to Secondary Customs and/or Secondary Immigration and, if so, how to get there.
- To implement a single integrated database system for international passengers arriving at the Vancouver International Airport that:
    - creates a file for each passenger on arrival at the Primary Inspection Line;
    - records the time when the passenger clears the Primary Inspection Line;
    - records whether the passenger is expected to proceed to Secondary Customs and/or Secondary Immigration;
    - records the time by which the passenger is required to reach each Secondary location;
    - records the time when the passenger actually reaches, and subsequently clears, each Secondary location and the Point; and
    - issues an alert to all Border Services officers if a passenger does not reach the next Secondary location within a predetermined period of time.
- To impose a positive duty on specified Border Services officers to page and actively search for any passenger for whom an alert has been issued under the immediately preceding paragraph.
- Until the single integrated database system recommended above is in operation, to ensure that all Border Services officers at the Vancouver International Airport have prompt and easy access to both the Integrated Primary Inspection Line Database and the Field Operations Support System.

Communication between arriving passengers and greeters awaiting them

2. I recommend that the Attorney General urge the appropriate federal minister or ministers:

- To implement a policy of inviting each prospective immigrant, when applying overseas for immigrant status, to consent in advance to their sponsor being informed when they do enter Canada.
- To impose a duty on a Canada Border Services officer at the Vancouver International Airport, who receives an enquiry from a greeter about an arriving international passenger:

  - To determine whether the passenger has crossed the Primary Inspection Line.
  - If the passenger has crossed the Primary Inspection Line more than two hours ago, to page the passenger and to record in the passenger's file in the proposed single database system the particulars of the greeter, the greeter's relationship to the passenger, any special assistance that the passenger may require and, where appropriate, a message from the greeter to the passenger.
  - If the passenger has not crossed the Primary Inspection Line, to make a note in the proposed single database system containing similar information.
- To impose a duty on a Border Services officer at the Vancouver International Airport, who deals with an arriving international passenger at Secondary Customs or Secondary Immigration, to inform the passenger:
  - of the details of any enquiry by a greeter that is recorded in the proposed single database system; and
  - how the passenger may communicate with the greeter.
- To install in the Customs Hall one or more closed-circuit TV monitors showing the greeters who are waiting in the public Meeting Area of the International Terminal Building, unless the minister is satisfied that there are legitimate security reasons for not doing so.

Interpretation services

3. I recommend that the Attorney General urge the federal Minister of Public Safety to ensure that:

- CBSA officers at the Vancouver International Airport receive training, regularly updated, on what interpreter services are available to them and to arriving international passengers, and how to access such services.
- CBSA provide its officers at the Vancouver International Airport with adequate resources (e.g., interpreter services, printed multilingual forms, etc.) to ensure that arriving international passengers:
  - know where they have to go within the Customs Hall, and how to get there;
  - know what is being asked of them, when an officer is required to seek specific information, and are able to communicate such information to the officer;

  - know if a greeter has attempted to contact them; and
  - are assisted in their own language, if they appear to be confused or distressed.

VANCOUVER AIRPORT AUTHORITY

Communication between arriving passengers and greeters

4. I recommend that the Attorney General urge the federal Minister of Public Safety:

- To install, in the Vancouver International Airport's Customs Hall, a digital Passenger Information Board on which waiting greeters can place their name, so that arriving passengers are aware of their presence.
- To permit the Vancouver Airport Authority's customer service agents to page from the public Meeting Area into the Customs Hall, and *vice versa*.

Safety and security

5. I recommend that the Vancouver Airport Authority:

- Revoke the current "observe and report" mandate applicable to its contracted security patrollers.
- Set minimum standards for security patrollers that include:
  - training in first aid (including CPR) and verbal de-escalation techniques; and
  - an expectation that they will actively assist members of the public who are in distress.

Emergency and medical response

6. I recommend that the Vancouver Airport Authority, RCMP, Richmond Fire-Rescue, and BC Ambulance Service:

- Work together in formulating a plan of action for dealing with police use-of-force incidents at the Vancouver International Airport that evolve into medical emergencies.
- Train, with regular updates, their personnel on any such plan of action formulated by them, including live training exercises.

Public report on implementation of these recommendations

7. I recommend that, within two years of this report being made public, the provincial Minister of Public Safety and Solicitor General report publicly and in writing to the Legislative Assembly on the extent to which the federal government and the Vancouver Airport Authority have implemented the recommendations contained in this report, and if one or more recommendations have not been implemented, the reasons why.

POSTSCRIPT – POLICE INVESTIGATING THEMSELVES

8. I recommend that:

a. British Columbia develop a civilian-based criminal investigative body, which I suggest be named the Independent Investigation Office (IIO).

b. The IIO be mandated to investigate all police-related incidents occurring throughout the province, in which:

- "police-related incidents" include, but are not necessarily limited to, incidents:
  - in which a person dies or suffers serious harm:
    - i. while in the custody or care of a municipal police officer or RCMP officer, or
    - ii. the death or serious harm could be seen to be the result of the conduct of any municipal police officer or RCMP officer, or
  - which involve possible contravention, by a municipal police officer or RCMP officer, of:
    - i. any provision of the *Criminal Code*, or
    - ii. any other federal or provincial statute that, if the incident were investigated by a police officer, might in the minds of reasonable, informed members of the public undermine confidence in the police.
- "serious harm" means injury that:
  - creates a substantial risk of death,
  - causes serious disfigurement, or

  - causes substantial loss or impairment of mobility of the body as a whole or of the function of any limb or organ.

c. The IIO be accountable to the Ministry of Attorney General.

d. The IIO be led by a director who is neither a current nor former police officer, appointed by Order-in-Council for a fixed, renewable term of five or six years.

e. No member of the IIO shall have served anywhere in Canada as a police officer.

f. Notwithstanding para.(e), during the first five years of operations, the IIO may include as members former police officers, provided that:

- they have not served as a police officer in British Columbia within the preceding five years,
- they take no part in any investigation relating to a law enforcement agency in which they were employed,
- they constitute no more than a minority of the investigators who are assigned to a particular investigation, and
- their employment with the IIO expires by the end of the five-year transitional period.

g. To ensure the IIO's unquestioned authority to act, its essential powers be entrenched in legislation, such as:

- the IIO director and investigators have the status of peace officers,
- the chief constable or commanding officer of the RCMP of the jurisdiction in which a police-related death occurs must immediately advise the IIO of the incident,
- pending arrival of the IIO at the incident scene, the chief constable or commanding officer of the RCMP must ensure that the scene is secured and that officers involved in the incident are segregated from each other,
- officers involved in the incident must not communicate with each other about the incident, except as authorized by the IIO,
- the IIO becomes the lead investigative agency, and the home police department or RCMP has no investigative responsibility or authority, except as granted by IIO,

  - a witness officer must promptly make himself or herself available for an interview with the IIO investigator, and must promptly deliver to the IIO all notes, reports, and other investigative materials relevant to the incident, and
  - a respondent officer may be – but is not compelled to be – interviewed by the IIO, and must in all cases promptly deliver to the IIO all notes, reports, and other investigative materials relevant to the incident.

h. In every police-related incident assigned to the IIO, a special prosecutor be appointed in accordance with the *Crown Counsel Act*.

i. The provincial Ombudsman have jurisdiction over the IIO.

PART 2

THE COMMISSION OF INQUIRY

PART 2: THE COMMISSION OF INQUIRY

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A. THE COMMISSION

1. Appointment of Commissioner

On November 19, 2007, John Les, the provincial Minister of Public Safety and Solicitor General, announced the government's commitment to hold a commission of inquiry into the circumstances surrounding the death of Robert Dziekanski at the Vancouver International Airport on October 14, 2007, and a review of the appropriate use and policies currently employed by law enforcement officers in British Columbia with respect to conducted energy weapons.

The minister stated at that time:[1]

> This incident has British Columbians, Canadians and people all over the world seeking answers with regard to not only this human tragedy, but how the province welcomes the world to our Airport. By calling a full public inquiry, we want everyone to know that all the facts will be put on the table, we will take action based on those facts and we will learn from this tragedy.

On February 15, 2008,[2] I was appointed sole commissioner under the *Public Inquiry Act*[3] to conduct two separate inquiries:

- ***a study commission*** to inquire into and report on the use of conducted energy weapons by constables, sheriffs, and authorized persons in British Columbia, and
- ***a hearing and study commission*** to inquire into and report on the death of Mr. Dziekanski.

Throughout this document we have provided website references, though it must be kept in mind that they may change over time or become unavailable. They are up to date as of May 20, 2010. Wherever possible, we have provided references to the original documents.

[1] See http://www2.news.gov.bc.ca/news_releases_2005-2009/2007PSSG0070-001490.htm.

[2] See Order in Council 92, approved and ordered on February 15, 2008.

[3] S.B.C. 2007, c. 9. The *Public Inquiry Act* can be viewed on the Inquiry website, at http://www.braidwoodinquiry.ca/legislation.php.

When Attorney General Wally Oppal announced my appointment on February 18, 2008, he stated:[4]

> Given the overlapping reviews and investigations now being conducted, combined with the jurisdictional complexity of this tragic incident, we felt it prudent to adopt a two-phased approach. The federal government has indicated that it will co-operate.

This report deals only with the hearing and study commission into the death of Mr. Dziekanski at the Vancouver International Airport. On July 23, 2009, I released my study commission report respecting the use of conducted energy weapons.[5]

2. Terms of reference

Section 2 of the *Public Inquiry Act* states that the Lieutenant Governor in Council may establish a commission to inquire into and report on a matter that it considers to be of public interest. When it does, the Lieutenant Governor in Council must define the purposes of the commission, set the terms of reference of the inquiry, and designate the commission as a study commission, a hearing commission, or both.

The Lieutenant Governor in Council designated this inquiry as a hearing and study commission.[6] The parts of the Order in Council applicable to this inquiry state as follows:

THE THOMAS R. BRAIDWOOD, Q.C., COMMISSIONS OF INQUIRY ORDER

Definitions

> 1. In this Order:...
> **"Mr. Dziekanski"** means Mr. Robert Dziekanski, who died at the Vancouver International Airport on October 14, 2007....

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[4] See http://www2.news.gov.bc.ca/news_releases_2005-2009/2008AG0006-000220-Attachment1.htm#.

[5] Available at the Commission of Inquiry's website: http://www.braidwoodinquiry.ca/reports.php.

[6] The full text of the Order can be found in Appendix A.

Establishment of two commissions

2. (2) A hearing and study commission, called the Thomas R. Braidwood, Q.C., Hearing and Study Commission, is established under section 2 of the *Public Inquiry Act* to inquire into and report on the death of Mr. Dziekanski.

(3) Thomas R. Braidwood, Q.C., is the sole commissioner of each of the commissions established under this section.

Purposes of the commissions

3. (2) The purposes of the hearing and study commission established under section 2(2) are as follows:

(a) to provide Mr. Dziekanski's family and the public with a complete record of the circumstances of and relating to Mr. Dziekanski's death;
(b) to make recommendations referred to in section 4(2)(c).

Terms of reference

4 (2) The terms of reference of the inquiries to be conducted by the hearing and study commission established under section 2(2) are as follows:

(a) to conduct hearings, in or near the City of Vancouver, into the circumstances of and relating to Mr. Dziekanski's death;
(b) to make a complete report of the events and circumstances of and relating to Mr. Dziekanski's death, not limited to the actual cause of death;
(c) to make recommendations the commissioner considers necessary and appropriate;
(d) to submit a report to the Attorney General on or before a date to be determined by the Attorney General in consultation with the Commissioner.

3. The Commission team

In the weeks following my appointment, I appointed **Dr. Leo Perra** to act as Executive Director, and **Cathy Stooshnov** to act as Manager of Finance and Administration. They both brought a wealth of administrative experience – Dr. Perra as a former president of a community college and executive director of several previous public inquiries, and Ms. Stooshnov as an administrator for numerous other public inquiries since the early

1990s. Together, they secured office space for the Inquiry in downtown Vancouver, hired staff and made administrative arrangements for our hearings.

I retained as Commission Counsel **Art Vertlieb, Q.C.**, a partner in the Vancouver law firm of Vertlieb Dosanjh. Mr. Vertlieb brought to this task his considerable experience as a senior civil, criminal, and administrative law litigator. I retained **Patrick McGowan** as Associate Commission Counsel. Mr. McGowan is an experienced criminal and civil law practitioner in Vancouver.

In light of the many public policy issues arising out of the Terms of Reference for both Commissions, I retained **Sharon Samuels** as Research Counsel. She has served in a similar capacity in several other public inquiries since the mid-1990s. I retained **Keith Hamilton, Q.C.**, as Policy Counsel. Mr. Hamilton has acted as policy counsel and principal report-writer for numerous previous public inquiries.

I also retained **Chris Freimond**, of Chris Freimond Communications Inc., as our communications manager. He advised the Inquiry on matters of public and media communications, and was the key contact person for the Commission.

Finally, I express my thanks to former Provincial Court Judge **Dolores Holmes**, who agreed to serve in an advisory capacity during the evidentiary hearings, to **Len Giles**, who served as registrar, and to **Pattie Kealy** of McEachern & Associates, who acted as court recorder and transcriber.

A listing of the complete Inquiry staff, contractors, and suppliers is included in Appendix B.

I would like to express my sincere appreciation to all members of the Inquiry team for the professionalism, hard work, and enthusiasm they brought to this task. While I accept sole responsibility for my findings of fact, findings of misconduct, and recommendations, in all other respects it was a team effort, and all members of the team can be proud of their contributions.

B. THE EVIDENTIARY HEARINGS

1. Rules of procedure

Section 9(1) of the Act authorizes a commission to control its own processes and to make directives respecting practice and procedure, in order to facilitate the just and timely fulfillment of its duties.

Accordingly, I approved a 44-paragraph *Practice and Procedure Directive for Evidentiary Hearings,*[7] based in part on precedents used by other public inquiries from across Canada.

2. Participants and counsel

Section 11 of the Act permits any person to apply to a commission to be a participant. A commission may accept an applicant as a participant after considering all of the following:

- whether, and to what extent, the person's interests may be affected by the findings of the commission;
- whether the person's participation would further the conduct of the inquiry; and
- whether the person's participation would contribute to the fairness of the inquiry.

I granted participant status to 16 individuals and organizations, all of whom were represented by counsel:

Participant	**Counsel**
Attorney General of British Columbia	Craig Jones
BC Civil Liberties Association	Grace Pastine Sara Dubinsky
Constable Bill Bentley	David Butcher Anila Srivastava

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[7] See Appendix E. The Directive can also be viewed on the Inquiry's website: http://www.braidwoodinquiry.ca/procedure_directive.php.

Participant	Counsel
Government of Canada	Helen Roberts Mitchell Taylor, Q.C. Jan Brongers
Corporal Dale Carr	E. David Crossin, Q.C. Emilie LeDuc
Zofia Cisowski	Walter Kosteckyj Sonny Parhar
City of Richmond (Richmond Fire Department)	James Goulden Michael Kleisinger Geoffrey Trotter
Sergeant Pierre Lemaitre	Joe Doyle Anna Karlen
Constable Kwesi Millington	Ravi Hira, Q.C. Brendan Morley
Government of Poland	Donald Rosenbloom
Public Service Alliance of Canada	Chris Buchanan Brett Matthews
Superintendent Wayne Rideout	Alexander Pringle, Q.C. Anna Konye
Corporal Benjamin Robinson	Reginald Harris
Constable Gerry Rundel	G. E. (Ted) Beaubier
TASER International, Inc.	David Neave Jennifer Spencer
Vancouver Airport Authority	Dwight Stewart Cherisse Friesen

I express my thanks to Messrs. Vertlieb and McGowan, assisted by Jessica McKeachie and John Lunn, for the efficient organization of witnesses and conduct of the evidentiary hearings. I also express my appreciation to counsel for all participants, who rearranged their busy law practices in order to accommodate the timely conduct of these proceedings.

3. Hearings

The evidentiary hearings were originally scheduled to commence in the fall of 2008, but I postponed them several times to await the decision of the Criminal Justice Branch as to whether criminal charges would be laid arising out of the events at the Vancouver International Airport.

On December 12, 2008, the Criminal Justice Branch announced that no criminal charges would be approved, clearing the way for our evidentiary hearings to commence, which they did on January 19, 2009.

There were 61 days of evidentiary hearings between January 19 and September 23, 2009. I heard testimony from 91 witnesses, including several by teleconference. This evidence generated 5,500 pages of transcript.[8] Counsel for the participants filed written submissions, and made closing oral submissions over five days, between October 5 and 13, 2009.

Our evidentiary hearings were conducted in a large courtroom of the Federal Court of Canada, in a Vancouver office tower. It was conveniently located in the downtown core and was ideal for accommodating so many counsel, as well as members of the public and representatives of the print and electronic media. I extend my sincere thanks to the Federal Court, and particularly to Mr. Sam Thuraisamy and Ms. Julie Gordon, for providing the courtroom and offices.

The first purpose of this Commission of Inquiry is to provide Mr. Dziekanski's family and the public with a complete record of the circumstances of and relating to his death. I am confident that this goal has been achieved. It is my hope that this report will assist Mr. Dziekanski's mother and family in finding some peace and closure.

4. Findings of misconduct

The Supreme Court of Canada has ruled[9] that a commission of inquiry may make findings of misconduct, which it interpreted as "improper or unprofessional behaviour," or "bad management." The Court recognized that a finding of misconduct may damage a person's reputation, but damaged reputations may be the price that must be paid to prevent a recurrence of a disaster. Findings of misconduct should not be the principal focus of a public inquiry; they should be made only in those circumstances where they are required to carry out the mandate of the inquiry.

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[8] See Appendix D for a list of witnesses who testified at the evidentiary hearings, and the dates of their testimony. This information, along with the transcripts of witnesses' testimony, is also available on the Commission's website, at http://www.braidwoodinquiry.ca/hearing_transcripts.php.

[9] *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*, [1997] 3 S.C.R. 440 (S.C.C.).

The Court added that a commissioner should endeavour to avoid making evaluations of his or her findings of fact in terms that are the same as those used by courts to express findings of civil or criminal liability. However, a commissioner should not be expected to perform linguistic contortions to avoid language that might conceivably be interpreted as importing a legal finding.

Section 21 of the *Public Inquiry Act* legislates a commission of inquiry's authority to make findings of misconduct. It states:

> (1) Subject to this Act and the commission's terms of reference, a hearing commission may engage in any activity necessary to effectively and efficiently fulfill the duties of the commission, including doing any of the following:...
>
> (d) making a finding of misconduct against a person, or making a report that alleges misconduct by a person.

Section 11 establishes procedural safeguards, before a finding of misconduct can be made:

> (2) If a hearing commission intends to make a finding of misconduct against a person, or intends to make a report that alleges misconduct by a person, the hearing commission must first provide the person with
>
> (a) reasonable notice of the allegations against that person, and
>
> (b) notice of how that person may respond to the allegations.

Near the conclusion of the evidentiary hearings, Commission Counsel delivered several Confidential Notices, which advised recipients that "the Commissioner *may* make the following findings that *may* amount to misconduct," and then itemized those possible findings. Counsel for the recipients of those Notices had the opportunity to address the allegations during their closing written and/or oral submissions.

On May 12, 2009, counsel for the four RCMP officers who had dealt with Mr. Dziekanski at the Airport applied to me confidentially, under our *Practice and Procedure*

Directive for Evidentiary Hearings, for an Order that the Notices did not sufficiently particularize the misconduct alleged against them. In a confidential written Ruling dated May 22, 2009, I ordered further particulars in relation to one paragraph of the Notices, but otherwise dismissed the applications. Commission Counsel subsequently delivered revised Notices of Misconduct.

On June 2, 2009, counsel for the same four officers applied to me confidentially for an Order that the Notices of Misconduct be quashed as being beyond the authority of a provincial inquiry and outside the Terms of Reference of this particular Commission. On June 9, 2009, I issued a confidential Ruling dismissing these jurisdictional arguments.

The four officers applied to the BC Supreme Court for judicial review of both these Rulings and, in the course of doing so, disclosed the identity of their clients and the allegations of misconduct made against them. On June 15, 2009, Mr. Justice Silverman issued oral Reasons for Judgment dismissing the officers' claims.[10]

Three of the four officers (Constables Bentley, Millington, and Rundel) appealed that decision to the BC Court of Appeal. On December 29, 2009, the Court issued written Reasons for Judgment unanimously dismissing the appeal.[11]

5. Policy issues

The Terms of Reference include an instruction "to make recommendations the commissioner considers necessary and appropriate." Although unlimited on its face, I have interpreted this direction in light of the overall mandate of this hearing and study commission, which is to inquire into the events and circumstances of and relating to Mr. Dziekanski's death, not limited to the actual cause of death.

Since one of the accepted purposes of a public inquiry is to prevent the recurrence of a tragedy, this instruction to make recommendations must, at a minimum, focus on improvements respecting the handling of, and services provided to, arriving international passengers at the Vancouver International Airport, especially those who do not speak English. Consequently, I have concluded that I have been instructed to inquire into the policies, procedures, and practices of those agencies at the Airport that deal with, or provide services to, arriving international passengers, specifically the Canada Border Services Agency (including Immigration and Customs) and the Vancouver Airport Authority.

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[10] 2009 B.C.S.C. 814.

[11] 2009 B.C.C.A. 604.

I invited the Canada Border Services Agency and the Vancouver Airport Authority to tender senior employees who could explain to me their policies, practices, and procedures on these matters, and what changes have been made since October 2007. I have summarized the evidence of those witnesses in Part 9 of this report, along with my recommendations for further improvements.[12]

C. THE COMMISSION'S REPORT

Section 28 of the *Public Inquiry Act* establishes the procedures to be followed, after completion of a commission's report. Subsection (1) directs a commission to make its report to the minister (in this case the Attorney General), setting out:

> (a) any findings of fact made by the commission that are relevant to the commission's terms of reference, and the reasons for those findings, and
> (b) if required by the commission's terms of reference, any recommendations of the commission.

The minister must submit the report to the Executive Council (Cabinet) at its next meeting. On receiving the report, the Executive Council may direct the minister to withhold portions of the report because of privacy rights, business interests, or the public interest. If it so directs, the minister must remove any portions to be withheld and, in the report, identify any withheld portions and, to the extent possible, summarize them.

---

[12] The Commission also invited members of the public to express, in writing, their views respecting the issues raised by the Terms of Reference. The names of the people who made submissions are set out in Appendix C. I express my thanks to them for their thoughts, and for the time they took to contribute to the work of the Commission.

Following its review of the report, the Executive Council must then direct the minister to lay the report (except any withheld portions) before the Legislative Assembly. The minister:

- must promptly lay the report before the Legislative Assembly if it is in session or will be in session within 10 days of receiving the direction;
- in any other case, must promptly file the report with the Clerk of the Legislative Assembly; and
- must make available to a participant a copy of the report if it includes a finding of misconduct against that participant, or alleges misconduct by that participant.

Section 28(8) is clear that: "A person [which I interpret to include a commissioner] must not release a report of a commission except in accordance with this section."

PART 3

MR. DZIEKANSKI'S TRIP TO CANADA

PART 3: MR. DZIEKANSKI'S TRIP TO CANADA

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A. PREPARATION FOR HIS TRIP

Robert Dziekanski was born in Bielawa, Poland, in 1967. He lived his entire life in Poland. After his mother, Zofia Cisowski, immigrated to Canada and settled in Kamloops, British Columbia, he made the decision in late 2007 to do so as well.

I heard evidence by video conference from four acquaintances and neighbours of Mr. Dziekanski, who live in Gliwice, Poland, a city of approximately 200,000, which is part of a metropolitan area around Katowice of approximately 2 million in southern Poland.

Iwona Kosowska has an apartment in the same building in which Mr. Dziekanski and his mother lived. She had known him for at least 20 years. She told me that Mr. Dziekanski was trained as a typesetter, but did jobs as a handyman before leaving for Canada. His great passion was geography. He had atlases of Canada and was excited about immigrating to, and travelling around, Canada. He was healthy, not taking any prescription drugs, smoked about 10 cigarettes a day (up to about 20 a day before his flight), and was a social drinker – he did not have a drinking problem and she had never seen him drunk. This would be his first flight, and he was nervous. He was concerned about turbulence and about speaking no languages other than Polish. Because of his nervousness, he had not slept for 48 hours before his flight. He was originally scheduled to travel two weeks earlier; she thought he may have changed his booking because of his nervousness. Mr. Dziekanski had bought a cell phone and had agreed to phone her after arriving in Vancouver and meeting his mother. In her opinion he was not an aggressive man, and he was not acting aggressively in the Pritchard video – "he was a helpless person begging for help."[13] She had never seen him act in the manner depicted in the video, and attributed his behaviour to being in a foreign country without knowing the language, not having a cigarette or water, and no one helping him.

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[13] Transcript, March 30, 2009, p. 19.

Magda Czelwinska lives several blocks from Mr. Dziekanski's apartment, and had known him for at least 20 years. She would see him several times a week, often while she was walking her grandchild to school. He was a normal, healthy young man, always happy and joyful. He painted her apartment, and when she received her twice-yearly coal supplies, he helped her put the coal away. He was excited about moving to Canada ("where there is milk and honey"). He loved his mother very much and was going to quit smoking as a surprise for her. He did not expect to have to communicate with Canadian officials, because he was under the impression that he would meet with his mother right away. She last saw him about three days before he left, and she did not see anything unusual about him. His only concern was whether he would be able to take with him all his books about Canada. She agreed that the Pritchard video of him smashing a wooden table against glass and throwing a computer on the ground was out of character. She had never seen him in this upset state, adding:

> ... [O]ne shouldn't be surprised because he was on the airport for ten hours, deprived of water and he didn't have cigarettes because he just quit smoking to surprise his mom.[14]

Ryszard Krasinski lived near Mr. Dziekanski and had known him for about 10 years. They met quite often while gardening and for social occasions such as birthdays and barbecues. They played chess and bridge together, and before leaving for Canada, Mr. Dziekanski gave him a portable chess board as a gift. Mr. Dziekanski had a huge collection of atlases and other geographical material – he had a very deep knowledge of geography. Mr. Dziekanski would have known Russian as well as Polish, because it was mandatory in school. He may have taken excursions to neighbouring countries such as Ukraine, Slovakia, and Germany. Mr. Dziekanski was a good tradesman (painting and installing tiles) and planned to open a contracting business in Canada after learning English. He was physically fit and a social drinker. He had never seen Mr. Dziekanski breaking other people's property, as shown on the Pritchard video.

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[14] Transcript, March 31, 2009, p. 6.

Several months before Mr. Dziekanski's departure, **Robert Dylski** had agreed to drive him to the airport. The afternoon and evening before he left, Mr. Dziekanski got progressively more upset and nervous. When Mr. Dylski came to pick him up at just before four in the morning to go to the airport, Mr. Dziekanski was on speakerphone with his mother in Canada. He was quite hesitant and opposing his trip to Canada and Ms. Cisowski was trying to convince him to come. According to Mr. Dylski:

> A So at this point he decided not to go, completely, but we all tried to convince him to go.
>
> Q And how was Mr. Dziekanski acting physically at that time?
> A Yeah, that was a very, very high panic that he was in because he never flew a plane and he was afraid of flying a plane. Yeah. And then everything he was talking about was related to his fear of flying.
>
> Q And we understand that Mr. Dziekanski was shaking and perhaps vomiting at that time?
> A Yeah. He was shaking for sure and he was holding onto a radiator – heat radiator .... And he was probably throwing up in my car. Yeah. If he didn't vomit in my car, we had a little bucket, but I cannot recall right now exactly what happened. Now I cannot remember whether he was vomiting at home or he was complaining about being dizzy, and that's why we took the bucket with us.[15]

He told me that Mr. Dziekanski held onto the radiator for 20 minutes – it was a panic attack because he was afraid of flying. He had never seen Mr. Dziekanski in this state before. However, once Mr. Dziekanski got into the car he was very calm and did not talk. He remained calm at the airport; he went to the bathroom and had a soft drink. Mr. Dziekanski had a cell phone, and they agreed that he would phone them a day or two after settling in with his mother in Canada. He told me that he had seen the Pritchard video, but had never seen Mr. Dziekanski act that way before.[16]

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[15] Transcript, April 2, 2009, p. 5.

[16] Aneta Czernel gave a similar account in a June 24, 2008, interview (Exhibit 119). See also the interview of Wojciech Dibon, dated June 24, 2008 (Exhibit 120).

B. FLIGHTS

1. Katowice, Poland, to Frankfurt, Germany

On October 13, 2007, Robert Dziekanski left Poland on the first leg of his trip to Vancouver, BC. Lufthansa Airlines Flight 3297, a Boeing 737, departed Katowice, Poland, at 6:20 a.m. local time, and arrived at Frankfurt, Germany, about an hour later. Poland and Germany are both nine hours ahead of Vancouver.

Jesus Fernandez Gonzales, the chief flight attendant (purser) testified by teleconference from Germany, through an interpreter. Before takeoff he discovered that the number of passengers sitting in business class was incorrect. He identified one passenger who had an economy class ticket, but the passenger did not understand English. Mr. Gonzales contacted the ramp agent, who acted as an interpreter. When he explained to the passenger that he had to move to the economy section, the passenger appeared a little bit astonished, not seeming to understand that he was sitting in the wrong place. The passenger agreed to move to the economy section and did so.

While talking to this passenger, Mr. Gonzales smelled a little bit of alcohol on his breath. He explained to the passenger that, in accordance with company policy, he would not be served any alcohol on the flight. When asked if that was okay, the passenger said it was. Mr. Gonzales also advised him not to consume any alcohol while in transit at Frankfurt, or he might not be allowed to board his flight to Vancouver. The passenger agreed.

There was nothing else about the passenger's behaviour that Mr. Gonzales noticed – he was calm and behaved normally. He knows that the passenger did not drink any alcohol during the flight, but could not say whether he ate or slept. No other flight attendants reported any problems to him. Everything went normally during disembarkation at Frankfurt.

Although Mr. Gonzales did not know this passenger's name, and could not recall his appearance or clothing, I am satisfied that he was describing Mr. Dziekanski.

2. Frankfurt to Vancouver

Mr. Dziekanski left Frankfurt at about midday local time, on Condor Air, a Boeing 767. The flight to Vancouver was approximately 10 hours.

Adolf Buettner, the Condor Air purser, testified by teleconference. He greeted passengers as they boarded the flight, in German and English. Mr. Dziekanski did not react when Mr. Buettner greeted him, and Mr. Buettner noticed that he was sweating a little bit. Mr. Dziekanski initially sat in Row 34, but after the doors were closed he moved forward to Row 18. There were no problems or trouble with any passengers during the flight, or when they left the aircraft in Vancouver. He could not say whether Mr. Dziekanski drank any alcohol during the flight, and he was not told not to serve alcohol to any passenger.

After Mr. Dziekanski's death, Mr. Buettner gave a statement to a Condor Air duty cabin manager, in which he stated:

> He [i.e., Mr. Dziekanski] was slightly sweating and had glistening eyes. After consulting with the other colleagues, we assumed that he probably left a lot behind and would start new in Canada. The glassy eyes were rather indicated as a keeping back of emotions, as well as his agitation. Due to the language barrier we could not ask him and it did not seem that we would have success in doing so.
>
> After the doors of the aircraft were closed, the passenger moved from row 34 to row 18. He did not seem agitated. Rather he seemed a little bit helpless. At no time was he aggressive and he was very polite and thankful toward the crew.[17]

Christiane Hewer, another passenger on the Condor Air flight, remembered that the flight was only one-quarter full. Before takeoff, everybody spread through the aircraft. Mr. Dziekanski was sitting about eight to ten feet away from her, one or two rows ahead, by the right window. She noticed him from time to time during the flight.

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[17] Transcript, January 19, 2009, p. 39.

He watched a movie, slept a lot, was totally calm, did not attract attention, and was totally inconspicuous. There were no problems whatsoever during the flight. She did not get close enough to Mr. Dziekanski to tell whether there was a smell of alcohol on his breath. She did not keep track of whether he ate or drank during the flight.

C. FINDINGS OF FACT AND CONCLUSIONS

Based on this evidence, it is clear that Mr. Dziekanski was excited about immigrating to Canada, but at the same time was anxious about flying to Vancouver – it would be his first flight. It appears that he rescheduled his flight once because of nervousness, and might have cancelled his trip entirely except for his mother's phone conversation with him shortly before his departure. His holding on to a heat radiator in the apartment and his shaking and dizziness suggest that at times he was in a panicky state.

However, once he began the drive to the airport he settled down, and his behaviour on both flights appears to have been uneventful. Although he was sweating and had glistening eyes, he was calm and behaved normally. One witness told me that he smelled a little bit of alcohol on Mr. Dziekanski's breath, but there is no evidence that he consumed alcohol during the trip. On the long flight from Frankfurt to Vancouver, another passenger observed that Mr. Dziekanski slept a lot, and was otherwise totally inconspicuous.

PART 4

MR. DZIEKANSKI'S ARRIVAL IN VANCOUVER AND CLEARANCE TO ENTER CANADA

PART 4: MR. DZIEKANSKI'S ARRIVAL IN VANCOUVER AND CLEARANCE TO ENTER CANADA

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A. INTRODUCTION

In this part, I will review Mr. Dziękanski's movements from the time he disembarked from his flight at the Vancouver International Airport at approximately 3:15 p.m. on October 13, 2007, until he cleared Canadian Immigration and left the Customs Hall at approximately 12:40 a.m. on October 14, 2007.

Although some of his movements were captured on the closed-circuit video system in the Customs Hall area, his whereabouts for more than half of this time remain unknown.

B. VANCOUVER INTERNATIONAL AIRPORT ARRIVALS LAYOUT

There are seven areas of the Vancouver International Airport that make up the International Arrivals area (see Figures 1 and 2), discussed below. The first five are, collectively, a secure area controlled by the Canada Border Services Agency (CBSA):

- ***Primary Inspection Line*** – passengers arriving on an international flight come down escalators into a large hall, where they queue in order to speak to a Canada Border Services Agency officer at one of 24 counters. The officer asks a series of questions to make an initial determination whether the passenger is admissible into Canada or should be referred for further immigration or customs processing.
- ***Customs and Immigration Hall*** – after passing through the Primary Inspection Line, passengers proceed into the Customs and Immigration Hall, where they claim their checked luggage from large carousels.
- ***Secondary Inspection or Secondary Customs*** – passengers (Canadian or foreign) who have been referred for secondary customs inspection must go to this area for examination of their baggage or questioning about their declarations.
- ***Secondary Immigration*** – passengers who require further processing before they are allowed into Canada (e.g., study permit, work permit, new immigrants) must go into the Secondary Immigration area, where a Canada Border Services Agency officer interviews them.

Figure 1: International Terminal – Level 2

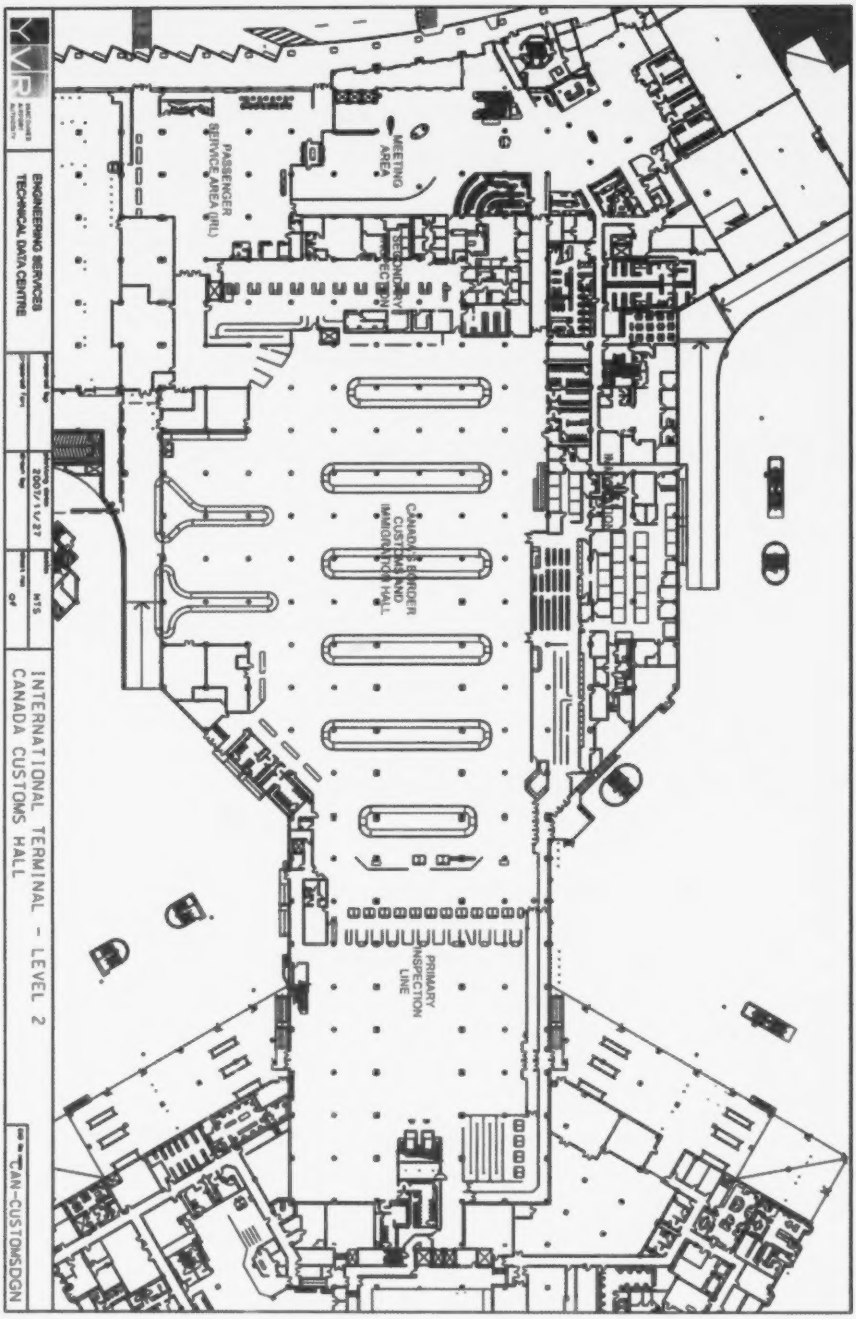
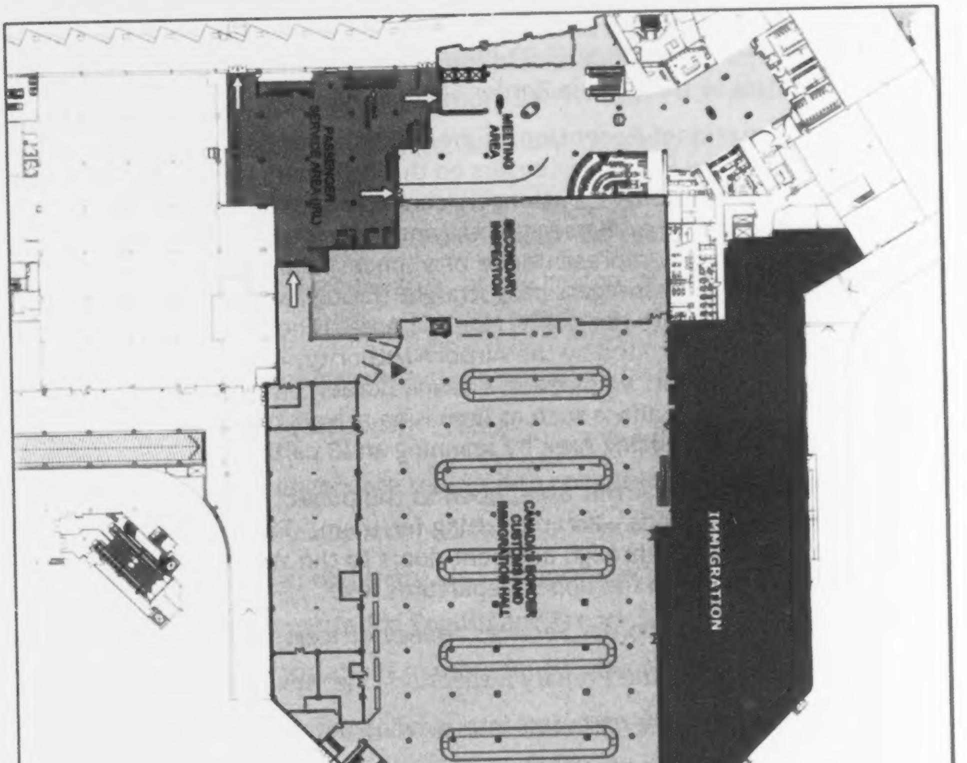

PASSENGER SERVICE AREA (IRL)
MEETING AREA
SECONDARY INSPECTION
IMMIGRATION
CANADA'S BORDER CUSTOMS AND IMMIGRATION HALL
PRIMARY INSPECTION LINE
ENGINEERING SERVICES
TECHNICAL DATA CENTRE
2007/11/27
NTS
INTERNATIONAL TERMINAL - LEVEL 2
CANADA CUSTOMS HALL
CAN-CUSTOMSDGN

Figure 2: Canada Border Services – International Terminal


PASSENGER SERVICE AREA (PSA)
MEETING AREA
SECONDARY INSPECTION
CANADA'S BORDER CUSTOMS AND IMMIGRATION HALL
IMMIGRATION
PRIMARY INSPECTION LINE
FROM AIRCRAFT

- ***Point*** – at the far end of the Customs and Immigration Hall, there is an exit where Border Services officers collect declaration cards from arriving passengers. Once passengers have passed the Point, they have cleared the Customs and Immigration Hall and are no longer under the control of the Canada Border Services Agency.
- ***International Reception Lounge (Passenger Service Area)*** – after passing the Point, passengers go through doors into the International Reception Lounge. Passengers connecting to a domestic flight check their bags here. Passengers staying in Vancouver who are meeting a tour company representative or a limousine driver do so here. Otherwise, passengers pass straight through and out automatic swinging glass doors into the public Meeting Area. The International Reception Lounge, controlled by the Airport Authority, is not accessible to the public. Airport employees, Canada Border Services Agency officers, and authorized civilians such as limousine drivers can access this area from the public Meeting Area by scanning an ID card.
- ***Meeting Area*** – this area, open to the public, is where passengers meet family or friends who are waiting for them. They leave this lower level of the Airport through adjacent doors to the street and parking, or take an escalator to the upper Departures level.

According to several Canada Border Services Agency officers, there would typically be about 15 officers working at the Primary Inspection Line, several officers acting as "rovers" circulating among the carousels interviewing passengers, 10 officers working in Secondary Immigration, and 10-15 officers working Secondary Customs and the Point. In October 2007 there was a "disembarkation screening team" that would meet some arriving aircraft and check washrooms to ensure that everyone had appropriate travel documents. There were pay phones located throughout the Customs Hall for passengers to phone out, but there was no way for a person to phone directly into the hall to contact a passenger. However, a customer service agent could, on behalf of a waiting friend or relative, phone through to another agent working at the Primary Inspection Line, although that was done infrequently.[18] In addition, an Immigration officer in the Customs Hall could page a passenger inside the Customs Hall area.[19]

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[18] Transcript, January 21, 2009, p. 93.

[19] Transcript, January 22, 2009, p. 29.

C. THE PRIMARY INSPECTION LINE

Patricia Hunter was a customer service agent on duty when Mr. Dziekanski's flight arrived at the Vancouver International Airport shortly after 3:00 p.m. She was employed by Marquise Customer Services, a private company that contracts with the Airport Authority to provide certain customer services. She wore a uniform with "Customer Service" written on the back and front. On that day she was acting as a greeter in the International Arrivals area, at the bottom of the escalator just before the Primary Inspection Line. Her duties were to manage the queue so that incoming passengers would get to the inspector in the order in which they came into the hall, and to answer passengers' questions.

Arriving international passengers are required to complete a Customs Declaration Card before reaching the Primary Inspection Line. The form is usually distributed to passengers during the flight, and there also are forms available in the International Arrivals area. The form is printed in English and French. There are books in the Customs area that have translations in other languages, including Polish.

Condor Air was the only arriving flight at that time. By about 3:15 or 3:30 p.m. all the other passengers from that flight had come through the Primary Inspection Line, had been cleared, and had gone. She saw Mr. Dziekanski enter the queue in the inspection area.[20] It was very unusual to see a solitary passenger arrive after everyone else had moved through. He was walking very steadily, staring straight ahead. Ms. Hunter approached him and asked if he had his Customs Declaration Card. He looked down momentarily at the form she was holding, and then reverted to looking straight ahead. She realized that she would not be able to communicate with him so, by hand signals, she indicated that he should proceed ahead and speak with a Border Services officer. He followed her directions. He had nothing in his hands. She did not notice any odours on him, but he had a small sheen of perspiration over his lip.

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[20] Closed-circuit video showed Mr. Dziekanski entering this area at 3:34 p.m.

Ms. Hunter observed that Mr. Dziekanski and the Customs officer communicated for a few moments. Then, the officer took Mr. Dziekanski over to a table, where he took out the booklet with the translations, gave a translation to Mr. Dziekanski, and then told Ms. Hunter that he was Polish. He left Mr. Dziekanski there to complete his form. For about 15-20 minutes Ms. Hunter observed Mr. Dziekanski looking at the translation book and then at his form, but she was not able to see whether he wrote anything on his form. She observed him pull out a handkerchief and wipe perspiration from his face frequently, but saw no signs of agitation, aggressive behaviour, or impairment. She did not intervene to assist him in completing the form because she had been trained not to. It is a confidential document, and if she were to coach a passenger about how to complete the form it may jeopardize any prosecution for smuggling.

Another Marquise employee, **Peter Dore**, had a brief encounter with Mr. Dziekanski before he reached the Primary Inspection Line. He described Mr. Dziekanski as having a disturbed look on his face and sweating profusely. However, Mr. Dore did not feel threatened, did not feel the need to report anything to security, and did not consider any medical procedures necessary. He did, however, adopt several parts of the written statement he gave to the RCMP to the effect that he felt uncomfortable with Mr. Dziekanski standing so close to him, that Mr. Dziekanski had a scary look about him, and that he could be a person of violence.

Monica Kullar came on duty as a Canada Border Services Agency officer at 4:00 p.m. on October 13, 2007. She was assigned to the Primary Inspection Line. Some time after another officer had shown Mr. Dziekanski the translation book, Mr. Dziekanski approached her booth. He was speaking rapidly in Polish and waving his declaration card at her. He repeatedly pointed at the part of the card stating what airline he had arrived on and showed her his boarding pass stub. He had written in "SAMOLOT," which means "airplane" in Polish. She wrote in "DE6070," which meant Condor Air Flight 6070. He showed her his passport with a visa. She marked the declaration card to show he was travelling alone and that he was a visitor as opposed to a resident. He had completed the other parts of the card correctly, except that he had repeated his birthdate and citizenship in the three spaces reserved for information about others travelling with the passenger, so she crossed out those entries. She stamped the front of the card, and on the back of the card made notations requiring secondary immigration and customs processing, which was mandatory when there was a language issue.

Ms. Kullar scanned his passport into the computer and made entries into the computer about immigration and customs referral. Her normal practice, after processing a passenger through the Primary Inspection Line, was to point them behind her to go into the next section, although she could not remember what she did in this case. The only thing about Mr. Dziekanski that caused her to remember him was that he had sweat rolling down and dripping off his chin, but he was not sweating from his chest or underarms. Notwithstanding the language barrier, he was courteous and she had no concerns of personal security and did not feel any physical threat. Officers working on the Primary Inspection Line do not call for translators; that is left to officers at Secondary Immigration or Secondary Customs. Her dealing with him lasted only about 30 seconds, and according to a computer record, she completed her processing of him at 4:09 p.m.

Between 10 and 11 o'clock that evening she received a phone call from an officer in Secondary Customs or Immigration about Mr. Dziekanski. He asked what time the Condor flight had landed. She checked the clipboard and said approximately 4 p.m. She asked the officer if he was still sweating, and the officer said no.

At about 12:50 a.m. on October 14, she saw Mr. Dziekanski standing with another officer, who was enquiring of several other officers if they were done with Mr. Dziekanski in that area. Mr. Dziekanski appeared a lot calmer and was no longer sweating. In her experience, she had never heard of a passenger being in the Customs terminal for so long – by now he had been there for nearly nine hours.

According to Ms. Kullar, in October 2007 one could not tell from the computer record whether a passenger who had been processed through the Primary Inspection Line was still in the secure area or had passed the Point. That could only be ascertained by a visual inspection of the secure area or by reviewing all declaration cards that had been turned in that day, which could total 20,000.

D. HIS DISAPPEARANCE FOR MORE THAN FIVE HOURS

Border Services Officer **Trevor Gross** reviewed all the video footage between 4:00 p.m. on October 13 and 1:30 a.m. on October 14, 2007, recorded on the 16 closed-circuit cameras in the secure Customs Hall area and the public Meeting Area. He identified 17 video segments showing Mr. Dziekanski.

There are four segments, between 4:05 p.m. and 4:11 p.m., showing Mr. Dziekanski passing through the Primary Inspection Line, arriving near Secondary Immigration, walking back toward the Primary Inspection Line, and checking a baggage monitor screen near the Primary Inspection Line. The next segment begins at 9:25 p.m.

None of the video cameras recorded Mr. Dziekanski between 4:11 p.m. and 9:25 p.m., a period of five hours and 14 minutes. A United Airlines customer service agent, **John Jubber**, was stationed at a baggage kiosk near the carousels, and sometime between 4:30 p.m. and 6:30 p.m. he saw Mr. Dziekanski (who appeared disheveled) walk by. No other witness saw him or knows where he was – he may have been in a washroom or he may have been standing, sitting, or lying down somewhere. I conclude that he remained within the secure Customs Hall area during this five-and-a-quarter-hour period. In the words of Mr. Gross:

> What I could tell from having reviewed all the cameras and all the video everywhere is that Mr. Dziekanski was not wandering around in the Customs Hall. He must have been stationary for us not to have caught him [on one camera or another].[21]

We do know that at about 4:30 or 4:45 p.m., **Julene Ann Widiner**, a Lufthansa German Airlines baggage agent assigned to the Customs Hall area, took Mr. Dziekanski's two bags off carousel 23 and placed them on the floor nearby. She determined from her computer that he had travelled from Poland through Frankfurt to

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[21] Transcript, January 20, 2009, p. 86.

Vancouver. She went into the Secondary Immigration office and asked an officer if Mr. Dziekanski had been processed. At her request, the officer looked through the cubicles at the back, and determined that Mr. Dziekanski was not there.

Ms. Widiner then went to the extension desk between the carousels and the Primary Inspection Line and asked the officer if Mr. Dziekanski had been processed. That officer checked the computer and told her that Mr. Dziekanski had been processed through the Primary Inspection Line at about 4:10 p.m. She then (about 5:15 p.m.) picked up Mr. Dziekanski's bags and put them behind the Lufthansa counter with a note attached summarizing her enquiries. When she went off duty at 5:30 p.m. the bags were still there.[22]

As I noted earlier, the Canada Border Services Agency had a small group of special enforcement officers ("rovers") who would circulate throughout the Customs Hall area, and often throughout the Airport generally, seeking out individuals who may be involved in unlawful importation/exportation of goods. The officer who was scheduled to work that evening as a rover had no recollection of seeing Mr. Dziekanski.[23]

E. HIS MOTHER'S ATTEMPTS TO REACH HIM

Mr. Dziekanski's mother, Zofia Cisowski, lives in Kamloops, BC, 350 km northeast of Vancouver. Several months before Mr. Dziekanski's flight, she asked a neighbour in the same apartment building, **Richard Gerald Hutchinson**, to accompany her to Vancouver to meet her son at the Airport. She did not want to drive in the city, and she felt that she needed help to communicate in English at the Airport. To compensate him for missing a day's work, she agreed to pay him $120 for accompanying her.

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[22] Ms. Widiner told me that the next day, after learning of Mr. Dziekanski's death, an Air Canada agent told her that at about 7:15 p.m. the preceding evening an agent in a blue uniform had picked up Mr. Dziekanski's bags and had taken them across the hall in the direction of Secondary Immigration. According to CBSA Officer Kal Bharya, he recovered Mr. Dziekanski's two bags from the Lufthansa counter at about 10:30 p.m.: Transcript, January 22, 2009, p. 67.

[23] Transcript, May 5, 2009, pp. 45 and 52, and Exhibit 122.

According to Mr. Hutchinson, they arrived at the Airport at about 1:20 p.m. on October 13, expecting the flight to arrive at 1:30 p.m. On their arrival at the International Arrivals area, they went over to an information counter in the Meeting Area and asked where would be the best place to wait for a passenger arriving from Poland.

According to **Christopher Arthur Richards**, a tourism/visitor information counsellor employed by Marquise and working at this counter, it had a prominent sign announcing that it was a "Tourist Information" or "Visitor Information" facility. His duty was to provide information to incoming passengers about hotel bookings, tourist attractions, and tours. He had no information about flights or other Airport matters. The information counter straddled the public Meeting Area and the International Reception Lounge. He told me that during an average day, between 100 and 200 people may approach him for information, and approximately half of them ask for information unrelated to tourism, such as flight arrivals or passengers. He tries to answer their questions, but if he cannot, he routinely refers people to the Marquise information desk at the top of the escalator or to the Canada Immigration office beyond the Meeting Area. Sometimes people get extremely agitated when he cannot give them the type of information they request, which is quite understandable given the location of the information counter.

Mr. Hutchinson and Mr. Richards both testified as to the events of that afternoon and the three or four times Ms. Cisowski and Mr. Hutchinson sought assistance from Mr. Richards. Although their accounts differ on minor points, the overall thrust of their evidence paints a consistent picture of confusion and growing frustration and distress.

Mr. Richards remembered Ms. Cisowski and a man coming to the counter between 12:30 p.m. and 1:30 p.m. She said she was waiting for her son, that it was taking awhile, and she wondered where he was. He told her that it normally takes quite some time to be processed, and to try to be patient. She could check the overhead flight board to determine when the flight had arrived, or she could go to the customer information desk at the top of the escalator. If she thought her son had any immigration issues, she could go to the Immigration office up the hall to the right.

According to Mr. Hutchinson, after waiting in the Meeting Area for an hour he went back to the information counter and asked for assistance. According to Mr. Richards, Ms. Cisowski came to the counter as well, and did the talking. They were told to check the monitor to find out what time the flight was arriving. According to Mr. Hutchinson he did so, and discovered that the flight had been delayed and would be arriving at 3:35 p.m. He went back and related this information to Ms. Cisowski, who was still standing by the glass doors. They continued to wait in this area.

According to Mr. Richards, at about 4:45 p.m. Ms. Cisowski and Mr. Hutchinson came back to the information counter. She was visibly distressed about her son's whereabouts. According to Mr. Hutchinson, they explained that they were waiting for a passenger from Poland who spoke no English and that they needed some help to find him. He was told that all they could do was stay there and wait, which they did for another hour.

According to Mr. Hutchinson, at about 6:30 p.m. he went back to the information counter and explained again their concern. He was told that there was nothing they could do, that there would be people to translate for the passenger and that if Ms. Cisowski was needed, she would be paged. At some point Mr. Richards told Ms. Cisowski that people sometimes wait six or seven hours for passengers to come out. They continued to wait, taking shifts so that one of them could go and get something to eat. Mr. Hutchinson had a photograph of Mr. Dziekanski, to assist in recognizing him.

Mr. Hutchinson told me that three or four times they told Airport personnel that Mr. Dziekanski had no experience flying and that he did not speak English, and that Ms. Cisowski had mistakenly told her son that she would meet him in the baggage carousel area (which she could not do, because it was within the secure Customs Hall area). Mr. Richards told me that people tell him surprisingly frequently that they had mistakenly arranged to meet the passenger in the baggage carousel area.

Mr. Hutchinson was getting discouraged and frustrated. He told me that at about 7:00 p.m. he went up the escalator to the information booth on the International Departures level. The Marquise employee at the booth, **Janet Sullivan**, told me that her job was to provide information to people about flight arrivals and departures and other Airport information. She said that Ms. Cisowski and Mr. Hutchinson told her they were waiting for a man coming from Poland. She checked all the flights arriving from Europe, and determined that they had all arrived.

Ms. Sullivan paged Mr. Dziekanski twice, about five to ten minutes apart. She told me that her normal practice is to tell people that a page cannot be heard in the Customs Hall, but she could not remember if she told them that. She could see that Ms. Cisowski was getting upset. When she learned from Ms. Cisowski that Mr. Dziekanski was immigrating to Canada, she recommended that they go to the Immigration office downstairs, and they left. Ms. Sullivan knew that Immigration officers do not give out information about arriving passengers (because of the *Privacy Act*), but sometimes when dealing with an immigrant they will seek a family member's help in translating. She knew there was no point in contacting the airline baggage agents, because they would not release information about a passenger's name, and she had no ability to interact with security personnel in the Customs Hall. According to Mr. Hutchinson, Ms. Sullivan told him that they would need an RCMP search warrant to find out if Mr. Dziekanski was on the flight.

Ms. Cisowski and Mr. Hutchinson went back downstairs. According to Mr. Hutchinson, he entered the Canada Immigration office, where he was directed down the hall to a phone. He picked up the phone and explained to an Immigration officer that they were looking for a Polish passenger from Condor Flight 6070 who was immigrating to Canada and who did not speak English, and requested her assistance to find him. The officer, **Tina Zadravec**, looked on the board in the shift supervisor's office that listed all people in detention and did not see anyone from Poland. She put the phone down and went into the Secondary Immigration area and did not see anyone sitting down or standing in a queue. She went into the secure cubicle area where examinations are conducted. Only one male was being examined, and she determined that he was an Iranian refugee claimant. According to Ms. Zadravec, she told Mr. Hutchinson that she could not see anybody in the Secondary Immigration area who could be the traveller he was looking for. She suggested that he contact the airline, phone Poland to make sure that he had departed on the flight, or wait at home until the traveller contacted them. She did not tell Mr. Hutchinson that she had not searched the carousel area of the Customs Hall or that she had the ability to page a passenger in the Customs Hall area.

According to Mr. Hutchinson, Ms. Zadravec said that they had been there too long; there was no way that it would take that long for someone to get through Immigration. She said that translators were available to assist passengers who did not speak English, and she assured Mr. Hutchinson that the passenger was an adult and would be fine. When he offered to give her Mr. Dziekanski's name so that she could check to see whether he had arrived, she said that she did not want his name, because for confidentiality reasons they were not allowed to say who comes off a flight. She suggested that he phone Poland to find out whether the passenger had boarded the flight. She told him that in all certainty there was no landed immigrant from Poland there and that they might as well go home. Mr. Hutchinson described the Immigration officer as cooperative and very pleasant.

Ms. Zadravec was asked about her ability, that evening, to determine whether a passenger had entered the Customs Hall:

Q	So you certainly, if I've got it right, were well aware that evening, that had you wanted to determine whether a passenger had entered the Customs Hall, that was something you could easily accomplish?
A	Yes.[24]

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[24] Transcript, January 22, 2009, p. 31. Mr. Binder Kooner subsequently testified on behalf of CBSA respecting its policies. He told me that an officer working in Secondary Immigration who received an enquiry about a passenger was expected to perform a visual inspection of the Secondary Immigration area and then report back. The officer was neither expected to track down an individual outside the Secondary Immigration area, nor expected to determine whether the passenger had crossed the Primary Inspection Line, including no expectation that the officer would access the database.

Ms. Zadravec was asked what, if anything, she would have done differently. She replied:

> I think about it a lot. But I can't – I wouldn't do anything differently. If I knew he was going to die, I would do everything differently. But in doing my job – I did my job.[25]

After their exchange with Ms. Zadravec, Ms. Cisowski and Mr. Hutchinson went back upstairs to Ms. Sullivan's information booth. Ms. Cisowski told her that an Immigration officer had told them that Mr. Dziekanski was definitely not there and they should go home. They had a brief conversation about him possibly having missed his connection, in which case he would not arrive until the next afternoon, after which they left.

Mr. Hutchinson told me that the Airport personnel made him feel disregarded and not important. He was convinced that Mr. Dziekanski was not at the Airport, and sometime after 10:00 p.m. they left the Airport and drove back to Kamloops, intending to return the next day.

Soon after their arrival in Kamloops, Ms. Cisowski came to Mr. Hutchinson's apartment and asked him to listen to a phone message. He thought that the message was not in English, and in any event, her phone went dead, so he did not hear it and could not say what it was about. She told him that she was going back to Vancouver, and she left.

F. SECONDARY CUSTOMS

The closed-circuit video shows that at approximately 10:30 p.m., Mr. Dziekanski approached the Point, where Customs officials directed him to the Secondary Customs area. Officer **Kal Bharya,** seen following him in that direction, told me that he quickly determined that there was a language barrier. Mr. Dziekanski had a Canadian visa with his passport, indicating that he was immigrating to Canada, but he did not have his Confirmation of Permanent Residence document with him. From his inspection of

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[25] Transcript, January 22, 2009, p. 39.

Mr. Dziekanski's airline ticket, he realized that Mr. Dziekanski had two additional pieces of checked luggage but did not have them with him. In his view there were no Customs concerns so, at approximately 10:50 p.m., he escorted Mr. Dziekanski over to the Secondary Immigration office, showed him where to sit down, and then explained the situation to the acting Immigration superintendent, Alexandra Currie.
Mr. Dziekanski indicated that he would like a glass of water, which another officer obtained. Officer Bharya went over to the Lufthansa counter, found Mr. Dziekanski's two bags, took them to the Secondary Immigration office, and then returned to his Customs duties. He told me that Mr. Dziekanski appeared frustrated, but was otherwise cooperative and compliant, did not seem aggressive, and acted just like any other typical traveller. He did not consider it necessary to seek the assistance of an interpreter during his dealings with Mr. Dziekanski.

CBSA Officer **Kelly McKenzie** assisted Officer Bharya in his initial dealings with Mr. Dziekanski in the Secondary Customs area. Her account of these events, and of Mr. Dziekanski's actions and demeanour, is largely consistent with Officer Bharya's.

G. SECONDARY IMMIGRATION

Acting Immigration superintendent **Alexandra Currie** told me she knew, from what Officer Bharya had told her, that Mr. Dziekanski was entering Canada as an immigrant, did not speak English, was unsure where his Confirmation of Permanent Residence form was, and needed assistance. She knew that he had arrived mid-afternoon. In her experience it was unusual for an arriving passenger to take six or seven hours to get to the Secondary Immigration office. She greeted Mr. Dziekanski. She made a sleeping gesture with her head and hands, and Mr. Dziekanski nodded, which she interpreted as meaning that he had been sleeping. She instructed Officer Van Agteren to process him.

Officer **Juliette Van Agteren** tried, unsuccessfully, to communicate with him in several languages. Knowing that he was immigrating, but not in possession of the

Confirmation of Permanent Residence form, she went around the counter to where Mr. Dziekanski's suitcases were, and asked him to open them. She saw a FedEx envelope, which contained the form she needed. She went back to her station, happy that they could proceed with his landing. She was aware that he had been there for an excessively long time, and wanted to expedite his processing. Officer **Sonya Purewal** assisted her.[26] Officer Van Agteren paged Mr. Dziekanski's mother in the Meeting Area, then repeated the page when Mr. Dziekanski corrected her pronunciation of his mother's first name.[27] They found a phone number for his mother in Kamloops; at about 11:30 p.m. she called and left a voice mail, asking her to call their office. They did not receive a response to the page or the voice mail, and after waiting awhile, she went out into the public Meeting Area to try to locate his relatives, but was unsuccessful. She returned to Secondary Immigration and, with the help of Officer Chapin, who knew some Polish words,[28] attempted to confirm that there had been no change to Mr. Dziekanski's marital status, dependents, or criminal convictions since he had applied for immigration. Mr. Dziekanski signed the form, and she gave him a copy, stamped his passport, and congratulated him on becoming a landed immigrant. She told me that during their interaction, she refilled Mr. Dziekanski's water cup four or five times. He was visibly fatigued and a little distracted; he was perspiring and his hair was disheveled with a day's beard growth, but he was otherwise calm. At no time was he uncooperative. In hindsight, one of her observations is poignant:

> This is a very uncomplicated procedure. It's usually a very happy occasion when an immigrant finally arrives in Canada. It usually takes a long time overseas to undergo all the examinations and the scrutiny. To receive one of these is quite a happy occasion. So it's one of the nicer aspects of an Immigration officer's job is [*sic*] to welcome new immigrants to Canada.[29]

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[26] Officer Purewal's testimony was consistent, in all important respects, with Ms. Van Agteren's.

[27] By this time, Mr. Dziekanski's mother and Mr. Hutchinson had left the Airport and were driving back to Kamloops.

[28] Ms. Van Agteren told me that she checked the CBSA database for Polish interpreters. Four were listed, but the three local ones were shown as no longer accessible, and the fourth, from back East, did not want to be contacted for interviews of less than two hours.

[29] Transcript, January 26, 2009, p. 70.

Ms. Zadravec, who had taken the phone call from Ms. Cisowski and Mr. Hutchinson several hours earlier, told me that she saw Mr. Dziekanski several hours later, seated in a chair in front of the Secondary Immigration counters, in conversation with Officer Van Agteren. Mr. Dziekanski looked tired and slightly disheveled. She told me, "I thought that the way he was physically moving, his mannerisms, were the way that I normally associate with a person who had been drinking. Otherwise he was calm, quiet. He seemed relaxed."[30] He was not sweating, and she did not detect any odours.

She realized that he fit the description of the man who Mr. Hutchinson had been asking about earlier, and she confirmed with Officer Van Agteren that this was the Polish immigrant. She told her about the earlier phone call, that Mr. Dziekanski's mother was at the Airport and that she (Ms. Zadravec) thought perhaps they might have decided to return to Kamloops. She made no attempt to contact Ms. Cisowski or Mr. Hutchinson, and did not discuss with any other officer whether that should be done.

Ms. Zadravec acknowledged that in her December 1, 2007 statement to the RCMP, she stated:

> But um ... the way he looked, the way he seemed to be behaving ... ah he looked like a man that I would of described as ... being drunk. And he looked to me like a guy who um ... the story I would have built around the way he was, he looked – amount of time for him to get to us ... the way he was physically behaving it seemed to me ah, my own explanation of it was that he looked like a guy who drank a heck of a lot on the airplane, maybe came off drunk, fell asleep, woke up and was still slightly drunk and um sort of having the physical ... um clumsiness that ... I normally associated with somebody who's been drinking too much.[31]

She was asked whether she has, since this event, received training on how to handle a request for information about an incoming passenger. She told me that she has received no training that would cause her to make enquiries whether a passenger had passed through the Primary Inspection Line. However, she has received training that in such circumstances she should refer a caller to the RCMP, and if the RCMP decides to come into the Customs Hall to investigate, they can do so.

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[30] Transcript, January 22, 2009, p. 33.

[31] Transcript, January 22, 2009, p. 48.

Gracie Churchill-Browne, an interpreter, was on duty from 10:30 p.m. that evening until 1:30 a.m. the next morning. At about 11:00 p.m., while sitting in Secondary Immigration, she observed Mr. Dziekanski sitting across from her, about three metres away. She witnessed an exchange between Mr. Dziekanski and several Border Services officers. They were trying to make themselves understood, and it was clear that Mr. Dziekanski did not speak the language. Ms. Churchill-Browne suggested that they call an interpreter and mentioned that she knew a Polish interpreter. Mr. Dziekanski looked tired and his eyes were red. He would pace around the room and at times appeared to be speaking to himself. The officers were trying to be helpful, and twice got water for him to drink. At some point a female Border Services officer came in, saw Mr. Dziekanski, and said to the other officers, "What? Is that man still here? His family have been waiting for him all day and they've just left for Kamloops." Later, after Mr. Dziekanski had left Secondary Immigration, Ms. Churchill-Browne remarked to a female officer that she hoped Mr. Dziekanski would stay at the Airport until daylight because he looked confused and very tired, and obviously did not know his way around. The officer responded, "Oh, he's a big boy."

Officer Currie, who had talked to Mr. Dziekanski briefly when Officer Bharya had brought him into Secondary Immigration, told me that she subsequently observed Mr. Dziekanski several times as she went about her business. There was nothing unusual about him. He was calm, appeared cooperative, and was attempting to respond. He had a little sweat on his forehead, as do many other travellers. There was no sign of aggression, animosity, or impairment. She overheard Officers Zadravec and Van Agteren talking about a phone call received earlier that evening from the public area, attempting to locate their son who was coming as a landed immigrant from Poland. She was asked what she did, once she realized that the call had been in

relation to
Mr. Dziekanski:

> Again, it was the officer who was handling the situation with Mr. Dziekanski. It was Officer Van Agteren. I was aware that she made attempts to find the family, not only by paging them, but going outside to look for them, and then phoning them with the telephone number that Mr. Dziekanski had provided.[32]

The closed-circuit video shows that Mr. Dziekanski cleared Secondary Immigration at approximately 12:40 a.m., one hour and 50 minutes after Mr. Bharya escorted him into Secondary Immigration. Officer Currie agreed that this was an unusually long time for someone to be in Secondary Immigration (she could process a simple case in 10 minutes), which she explained as being the result of attempts to help Mr. Dziekanski locate his family. She told me that it is not standard practice to involve an interpreter in the case of immigrants, since most of the processing, including the interview, medical examination, and criminal record check, is done overseas. It was not necessary in Mr. Dziekanski's case, because he was a lowest-risk traveller. In her opinion, the Immigration officers who dealt with Mr. Dziekanski that night exhibited courtesy and respect, and went above and beyond what is expected of them.

H. FINAL CLEARANCE TO ENTER CANADA

Border Services Officer **Adam Chapin** confirmed that, using hand gestures and his rudimentary knowledge of Polish, he assisted Officer Van Agteren in asking Mr. Dziekanski three questions about being married, having children, or having been arrested. After Mr. Dziekanski answered "no" to all three and signed the form, Officer Chapin went back to his other duties. Approximately half an hour later, he saw Mr. Dziekanski still sitting in the Secondary Immigration office. He confirmed with Officer Agteren that Mr. Dziekanski had been processed and was cleared to go. He conveyed this to Mr. Dziekanski and told him to follow him. He led him to Secondary Customs, where it was confirmed that he had cleared Customs. At about 12:40 a.m.

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[32] Transcript, January 26, 2009, p. 35.

Officer Chapin took Mr. Dziekanski to the Point, turned over his declaration form to the officer there, and told Mr. Dziekanski he was free to go. Officer Chapin said, in Polish, "Thank you, and have a good night," and Mr. Dziekanski said the same in return. Officer Chapin said that in his dealings with Mr. Dziekanski, he appeared slightly disheveled and was sweating a bit, but not profusely; his shirt was untucked; he stumbled once; he was calm, cooperative, and seemed happy. Officer Chapin thought he was perhaps a little "tipsy" or mildly intoxicated from alcohol. He adopted several statements in his written statement to the effect that Mr. Dziekanski appeared very intoxicated, had slurred speech, and was unsteady, walking with some stumbling.

Officer Chapin received a phone call from Mr. Dziekanski's mother at approximately 2:00 a.m.; she was returning the phone call that Officer Van Agteren had left. Mr. Chapin confirmed that her son was at the Airport and had cleared Immigration. He offered to go out into the public area and, if he found him, bring him back into the Immigration area and have him call her. She left her phone number. Officer Chapin did not see him in the Meeting Area or outside the terminal building. When he asked an RCMP officer there if he had seen an intoxicated Polish gentleman, the RCMP officer brought him into the International Reception Lounge. He saw Mr. Dziekanski lying on the floor; paramedics were trying to resuscitate him. Within 30 seconds, they pronounced Mr. Dziekanski dead. He helped the RCMP locate Mr. Dziekanski's documents and gave one of the officers the message from Mr. Dziekanski's mother and her phone number. He did not phone her himself, thinking it would be better left to the RCMP to tell her that her son had passed away.

I. FINDINGS OF FACT AND CONCLUSIONS

Before making any findings of fact or reaching any conclusions, I gave careful consideration to the written and oral closing submissions of counsel for the participants. Having done so, I have reached several conclusions.

First, there is no question that by the time Mr. Dziekanski reached Vancouver, he was fatigued, confused, and stressed. He was disheveled and sweating profusely around the face. I do not find any of this remarkable, given his fear of flying, the long trip, and his inability to speak English. Not finding his mother waiting for him at the baggage carousels (where she had said she would meet him) must have compounded his stress and confusion. Although several witnesses likened some of his behaviours to a person who was intoxicated, the evidence confirmed that he was not intoxicated.

Second, although some of Mr. Dziekanski's behaviours were unusual, those who dealt with him told me, almost without exception, that they did not feel threatened by him. Some of these witnesses had years of experience dealing with people who did not speak English, and they managed to communicate with Mr. Dziekanski. Some did not think that his behaviours or appearance were dissimilar to other weary travellers.

Third, Mr. Dziekanski was aware of time and place, and he appeared to understand what people were telling him or asking of him. He was compliant with Canada Border Services officers' requests for information and documents.

Fourth, one senses that Mr. Dziekanski's mother grew increasingly worried as time went on. She, with her travelling companion Mr. Hutchinson, did everything in their power to find out whether he had arrived, where he was, and when they could meet him. It must have been distressing to her to be powerless to do anything to help her son, who spoke no English, was afraid of flying, had no experience in international travel, and was obviously dependent on her.

Fifth, even now no one knows where Mr. Dziekanski was for five-and-a-quarter hours. He must have been somewhere within the secure Customs Hall area, and he must have been stationary in order not to have been captured on the closed-circuit cameras. How could an arriving passenger go missing in this type of secure facility for such a long time? Two matters concern me:

- One would think that the Canada Border Services Agency would want, for its own security purposes, to maintain tighter control than this on the movements of arriving international travellers. I heard evidence about a "disembarkation screening team" that would meet some arriving aircraft, check washrooms, and circulate throughout the Customs Hall to ensure that everyone had appropriate travel documents, which suggests to me a corporate desire to intercept stragglers who might try to enter Canada illegally. The Border Services officer acting as a "rover" that evening had no recollection of seeing Mr. Dziekanski, which suggests that the program was not effective in identifying stragglers.

- From a customer service perspective, it disturbs me that an arriving passenger could go unnoticed for more than five hours in a secure area (as opposed to a passenger lounge). The passenger could experience a medical emergency, or may simply need assistance. The fact that Mr. Dziekanski went unnoticed for more than five hours points to inadequate services to ensure that passengers move through the customs and immigration processes in an orderly and prompt manner.

Sixth, the Canada Border Services officers, customer service agents, and other people who interacted with Mr. Dziekanski could tell that he was struggling. They treated him respectfully, and several of them made a special effort to assist him. I particularly commend Canada Border Services Officers Bharya, Van Agteren, and Chapin for doing what one hopes any of us would do – show genuine compassion to another human being in need.

Seventh, I regret that I cannot be as complimentary about some of the actions of one Canada Border Services officer, Tina Zadravec. She took the call on the Immigration phone from Mr. Hutchinson and Ms. Cisowski and, after a survey of the Secondary Immigration area, told them that she could not see the person they were looking for. She suggested that they contact the airline, phone Poland to make sure he had departed on the flight, or wait at home until the traveller contacted them. I accept Mr. Hutchinson's testimony that Ms. Zadravec told him that in all certainty there was no landed immigrant from Poland there and that they might as well go home. I also accept Mr. Hutchinson's testimony that Ms. Zadravec declined his offer to give her Mr. Dziekanski's name so that she could check to see whether he had arrived, because for confidentiality reasons they were not allowed to say who comes off a flight. Ms. Zadravec herself told me that she had the ability to page an arriving passenger in the Customs Hall area and that she had the ability to determine whether a passenger had been on an arriving flight. I am satisfied that it was in part because of Ms. Zadravec's assurances that the traveller was not there and that they might as well go home, that Ms. Cisowski and Mr. Hutchinson left the Airport some time after 10:00 p.m. and returned to Kamloops.

I accept, based on the testimony of Mr. Kooner, that CBSA did not have an expectation that a Border Services officer working in Secondary Immigration would search the entire Customs Hall area for a passenger or would search the database to determine whether the passenger had crossed the Primary Inspection Line. Consequently, I do not fault Ms. Zadravec for taking neither of these steps. However, it was ill-considered and cavalier for her, not having taken those steps, to advise Mr. Hutchinson that in all certainty Mr. Dziekanski was not there and that they might as well go home.

If Ms. Zadravec had accepted Mr. Hutchinson's offer to give her Mr. Dziekanski's name and if she had taken steps to request a computer search, she would have learned that Mr. Dziekanski had indeed arrived. While I do not question her belief that she was under a duty not to disclose the fact of his arrival, she most certainly would not have told them he was not there and to go home. If they had not left the Airport, there is a good chance that they would have been there when Canada Border Services Officer Van Agteren went out to the public Meeting Area sometime after 11:30 p.m. to try to locate Mr Dziekanski's relatives.

Eighth, there is a haunting quality to one of the statements of Canada Border Services Officer Van Agteren, that it was one of the nicer aspects of her job to congratulate Mr. Dziekanski on becoming a landed immigrant and to welcome him to Canada. How awful that such a happy occasion would, within an hour, turn so tragic. It is difficult to fathom the sorrow that Ms. Cisowski must have felt. Their hopes and dreams for reunification and a life together in Canada had almost been realized, but now he was dead.

PART 5

MR. DZIEKANSKI'S ACTIVITIES IN THE INTERNATIONAL RECEPTION LOUNGE

PART 5: MR. DZIEKANSKI'S ACTIVITIES IN THE INTERNATIONAL RECEPTION LOUNGE

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A. INTRODUCTION

In this part of the report, I will review the testimony of approximately 20 people, such as Airport employees and contractors, and friends and relatives waiting for passengers, who observed and/or interacted with Mr. Dziekanski after he entered the International Reception Lounge (at 12:40 a.m.) and until the four RCMP officers arrived (at 1:28 a.m.). In some cases, I will include their testimony about what they observed after the RCMP officers arrived.

I will set out all the testimony of each witness in one place even though it spans numerous sequential events, rather than try to blend the testimony of all witnesses together in one seamless chronology. Imprecision about exactly when specific events happened make a seamless chronology impractical.

B. INITIAL ATTEMPTS TO ASSIST MR. DZIEKANSKI

Mr. Dziekanski passed through the Point at approximately 12:40 a.m. He is next seen on the Airport closed-circuit TV[33] at 12:54 a.m., exiting the swinging glass doors from the International Reception Lounge and pushing his suitcases on a luggage cart along the walkway into the public Meeting Area. He appears to be looking for someone, and then moves into a seating area hidden from view. Three minutes later he stands up and pushes his luggage cart across the waiting area to the corner nearest the glass doors into the International Reception Lounge, where he is again hidden from view.

At 1:04 a.m. **Joginder Dhari**, a cart attendant responsible for collecting empty luggage carts from around the Airport and returning them to the Customs Hall, is seen bringing some carts out of the International Reception Lounge through a different door. Three minutes later Mr. Dziekanski is seen lifting several suitcases over the handrail that separates the seating lounge in the public Meeting Area from the walkway that arriving passengers take after exiting the International Reception Lounge. It appears that Mr. Dziekanski placed the suitcases onto the walkway near the swinging glass doors and then crossed over the railing himself. He is seen making gestures near or against the glass doors. Mr. Dhari and another person are seen watching Mr. Dziekanski, and then at 1:08 a.m. Mr. Dhari is seen walking up the walkway to the glass doors.

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[33] On October 14, 2007, **Nancy Baggio**, at that time an Operations shift supervisor for the Vancouver Airport Authority, made copies of relevant closed-circuit TV footage and audio recordings, which I will frequently refer to during this section of my report. Most of the time references are taken from the footage of one closed-circuit TV that was mounted near the bottom of the escalators in the public Meeting Area, showing that area and, at a distance, the swinging glass doors that arriving international passengers come through after exiting the International Reception Lounge.

Mr. Dhari told me that when he first saw Mr. Dziekanski, he (Mr. Dziekanski) was in the middle of the public Meeting Area wandering around looking for something. Mr. Dhari thought he needed help, so he went up to him and asked what he needed. Mr. Dziekanski did not understand and did not respond. Mr. Dziekanski appeared healthy and strong, but seemed nervous and was making noises to himself. He was hitting the glass doors with his hand, trying to open them. Mr. Dhari agreed that Mr. Dziekanski's behaviour seemed bizarre, but Mr. Dziekanski did not threaten him, and Mr. Dhari was not afraid of him. Mr. Dhari suggested to a limousine driver (likely Mr. Meltzer) that he call security, which the driver did. Security officers came and talked to Mr. Dziekanski, but they could not help and they called the police. Mr. Dhari saw Mr. Dziekanski throw a chair against a wall and, after the police arrived, watched them use the conducted energy weapon. The officers wrestled with Mr. Dziekanski and put handcuffs on. At one point, one of the officers put his leg on Mr. Dziekanski's neck. Mr. Dhari is seen leaving the area at 1:34 a.m.

At 1:10 a.m. **Lorne Martin Meltzer**, a self-employed corporate valet, is seen walking along the public Meeting Area walkway toward the swinging glass doors. He told me that he was expecting to meet a client in the International Reception Lounge, who was arriving on a Cathay Pacific flight from New York. He saw Mr. Dziekanski on the public Meeting Area side of the doors. He appeared angry and distraught, and was smashing a chair against the glass doors, trying to get back into the secure area. Mr. Meltzer realized there was a language barrier. He told Mr. Dziekanski to "hold on" and pulled out and swiped his access card, and the doors opened. However, Mr. Dziekanski would not let him past. Mr. Meltzer got angry and, standing about 18 inches away, said in a loud voice, "Look, you fuckin' asshole, I need to get through here." Mr. Dziekanski calmed down, but Mr. Meltzer could still not get past him – Mr. Dziekanski had used suitcases and chairs to form a barrier. Mr. Meltzer hopped over the handrail and asked if any of the other people waiting for passengers spoke other languages. One woman (Ms. Ashrafinia), fluent in several languages, went over and spoke to Mr. Dziekanski. Mr. Meltzer called 911, but was put on hold, so he hung up. At 1:15 a.m. he went up the escalator to where a security guard was stationed, and told him that there was a man freaking out and that they needed to get someone down there quickly. After he returned downstairs (at 1:18 a.m.), a security guard approached and Mr. Meltzer told him about the flight arriving from New York and that it would be a good idea to alert Customs, so they could divert the arriving passengers away from the International Reception Lounge. At about 1:28 a.m. Emergency 911 returned his call, and he explained the situation and said that police were needed. The operator told him that officers were already on their way, at which point he saw them arriving. He told the officers that Mr. Dziekanski did not speak English and that he was freaking out. Mr. Meltzer told me that he did not personally feel any threat from Mr. Dziekanski. He was sweating, pacing, talking to himself, and upset, but "he wasn't outwardly attacking people or mad at people. He was just – just distraught, just tired."[34] However, he agreed that in one of his statements to the police he said that on a scale of one to ten, when ten is attacking another person, Mr. Dziekanski was at a nine. In his testimony he said:

> Q And so you weren't thinking that he was actually about to attack you, but he was just a little bit below that level.
>
> A I would say so.[35]

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[34] Transcript, February 3, 2009, p. 51.

[35] Transcript, February 3, 2009, p. 112.

After being referred to a portion of one of the statements he made to the police in which he described Mr. Dziekanski as pacing back and forth, screaming, and acting aggressively, there was the following exchange:

Q	And two points I'm going to suggest come out of that. One was that you thought this man was assuming some sort of territoriality over the space that he was occupying.
A	Correct.
Q	And you didn't want to go into that space because you were concerned about what might happen if you did?
A	Under the circumstances, correct, I was, like I – like I said in earlier testimony yesterday, I was in a suit and tie and I was still there in a professional level, and the way he had his suitcases lined up across like a border, I just didn't want to, like I said, I didn't want to cross that line, yes.
Q	And the second point that I'm going to suggest comes from that is that events unfolded very, very quickly.
A	Correct.
Q	And in the time that you were dealing with him there appeared to be a change in his demeanour?
A	Correct. Yeah, for a bit, yes.[36]

Mr. Meltzer agreed that in his statement to IHIT investigators, he had said that Mr. Dziekanski made a motion like he was going to go toward an officer while he held the stapler up in the air.

In his testimony, **Servideo Agraviador**, a Securiguard access control point guard at elevator 40, told me that the man who came to his station (clearly Mr. Meltzer) told him that there was a man in the International Reception Lounge making trouble and throwing a chair. The man causing trouble did not speak English, might be Russian, and must be stopped because he (Mr. Meltzer) could not get into the lounge to meet a passenger. Mr. Agraviador used his radio to call the Security Operations Centre, which included the following exchange:

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[36] Transcript, February 4, 2009, p. 2.

Guard I received a report that in IRL there is a guy who are [*sic*] making trouble there....
SOC What kind of trouble is there, physical trouble or just arguing?
Guard He said to me that he was throwing chairs.
SOC Copy that. We'll inform police.[37]

Jame Glenn Canzon was on contract to clean several bank offices and bank machines at the Airport. He is seen on the closed-circuit video passing through the glass doors into the International Reception Lounge at 1:17 a.m., and leaving through the other door at 1:28 p.m. He told me that he was going into the International Reception Lounge to clean the currency exchange office at the far end. He saw Mr. Dziekanski inside the lounge, standing near the swinging glass doors. The doors were closed. Mr. Canzon told Mr. Dziekanski that he needed to get in. Mr. Dziekanski spread his arms out like a T and said something that Mr. Canzon did not understand. Mr. Canzon swiped his card to open the doors, then pushed his cart through and passed by Mr. Dziekanski. He told me that Mr. Dziekanski's hair was sweating, perspiration was running all over his face, and he was making loud "rrr, rrr, rrr" sounds, but he felt he was harmless, "I'm not afraid 'cause he didn't do anything against me."[38]

Ms. Sima Ashrafinia arrived at the International Arrivals public lounge at 1:09 a.m., to meet her husband who was arriving on the Cathay Pacific flight from New York. When she first saw Mr. Dziekanski, he was in the public area, grabbing his luggage, and talking loudly to himself. He then lifted his luggage over the handrail dividing the lounge from the walkway that arriving passengers use after exiting the secure area, stepped over the railing, and tried to open the one-way swinging doors that are used by arriving passengers exiting the International Reception Lounge. An angry-looking man (Mr. Meltzer) started shouting loudly at Mr. Dziekanski in English that he was expecting his passenger any minute, using the F-word. This caused Mr. Dziekanski to begin shouting in return, and she observed that his face was upset, his breathing was fast, and he had sweat on his forehead. On a scale of one to ten, Mr. Dziekanski had been at level three before Mr. Meltzer's intervention, but went up to level nine afterward. She said to Mr. Meltzer, "He doesn't understand what you're saying. You're provoking him. Why don't you get the security?" Mr. Meltzer then backed off, and she saw him going up the escalator.

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[37] Exhibit 26, p. 1.

[38] Transcript, February 3, 2009, p. 19.

She initially thought Mr. Dziekanski was speaking Russian or Czech. She said "Russia," and then a few words in Turkish and then Italian, but he did not respond.[39] Mr. Meltzer came back down the escalator and walked toward Mr. Dziekanski. Mr. Meltzer told her that he couldn't find any security. He shouted at Mr. Dziekanski to move, then put his hand inside his suit jacket. Mr. Dziekanski clenched his fist, but relaxed when Mr. Meltzer pulled out his access card and scanned it, which caused the one-way swinging doors to open, and Mr. Dziekanski moved through into the secure area and dragged his luggage with him. She saw him pick up several objects from a counter just inside the swinging doors, including a keyboard and some binders. A cleaner (Mr. Canzon) passed through the swinging doors with his cart and went past Mr. Dziekanski, who barely noticed him – Mr. Dziekanski was minding his own business. She could see that Mr. Dziekanski was getting more and more frustrated, taking short fast steps, looking around at anything and nothing, and shouting. Using hand gestures and sign language, she persuaded him to put down a keyboard. At one point she was about one metre away from Mr. Dziekanski when he was holding a chair, but she felt comfortable and did not feel that he was going to hit her. A security person wearing a yellow jacket arrived. Mr. Dziekanski kept saying "polisa" or "politzia," but she wasn't sure whether he meant "police" or "please."

Ms. Ashrafinia saw four police officers arrive together. She and several other bystanders shouted to them, "He doesn't speak English." She also told an officer that Mr. Dziekanski was drunk and that he was asking for the police, and she heard Mr. Meltzer tell the police that he was out of control. She heard the lead officer turn backward and say something about "TASER®," and another officer responded "Okay" or "Yes."[40] When the four officers moved into the secure area and formed a half-moon around Mr. Dziekanski, he looked relieved. One of the officers made a hand gesture and said to Mr. Dziekanski, "Get down, get down" and took a step toward him. Mr. Dziekanski lifted both his arms in the air with his palms open and then turned away from the officers. When she next had a good view, she saw Mr. Dziekanski's hand go up, and he was holding a stapler, but he did not make a movement with it toward the officers. She then heard a buzz of electricity, saw Mr. Dziekanski cry out in pain, bend forward, and walk along past the counter. She heard two more sounds like electricity, and then Mr. Dziekanski was down on the ground in a fetal position, moaning as if in pain. She initially thought they had shot Mr. Dziekanski, but when she saw the wires coming out of the tip of the weapon she realized that they had TASERed him.

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[39] Another witness, **Marija Bosnjak**, an Alaska/Horizon Airlines customer service agent, asked Mr. Dziekanski in Croatian if he spoke Russian. He looked at her as if he was looking for someone to help him, but he did not respond.

She moved away from the scene and met up with her husband. When they returned to the scene a few minutes later, she saw Mr. Dziekanski lying on his back with his shirt ripped open. He had turned blue, and he was not moving or breathing. Before she and her husband left, she went up to an officer, said she had seen the events and offered to be interviewed, but the offer was declined.

Ms. Ashrafinia told me that when she watched an RCMP officer (Sgt. Lemaitre) say during a TV interview the next day that Mr. Dziekanski had been violent and that the officers had tried to calm him down, that wasn't what she had seen:

> Q You weren't happy with the report that you heard from … Sergeant Lemaitre, and you wanted –
> A Yes.
>
> Q – the record to be straight?
> A Yes. Because that wasn't true. That wasn't true at all. He wasn't, like, what they call – he wasn't I didn't feel he's violent, and he wasn't violent. And two officers TASERed

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[40] Another witness, **Alison Kula**, an Alaska/Horizon Airlines lead customer service agent, told me that one of the officers said to another officer, "Do you have your TASER out" or "Do you have your TASER ready?" but did not hear any response.

> twice, I'm hundred percent sure, at least four shots of that electricity.[41]

She acknowledged that she told the police several days after the incident, when asked about the officer's use of a conducted energy weapon, that they "think they have no other choice because he's out of control." She explained her statement as follows: "The reason I said that, I thought they are following their standard operation procedures. That's what they're supposed to do. That's what I meant."[42] When asked what she meant by her statement to the police, "I mean he deserved the TASER," she answered that in the context of the overall series of questions she was asked, she was really questioning whether Mr. Dziekanski deserved the weapon.

Alison Kula, an Alaska/Horizon Airlines lead customer service agent, described many of the same events as Ms. Ashrafinia. In addition, she told me that after the police arrived, one of the officers, in a very harsh tone, demanded Mr. Dziekanski's passport. She heard at least two conducted energy weapon discharges, and then he fell to the ground shaking. Three officers wrestled him on the ground, and after they handcuffed him, two of the officers moved away and the third continued to kneel by his legs. Mr. Dziekanski was lying on his front with his hands behind him, a little bit on his side, with his face turned away from her. She did not see him make any movement, but could not tell whether he was breathing.

About 30 seconds after the handcuffs were applied, she saw Mr. Dziekanski's hands go a bit purple. They turned very dark purple, then faded and started to turn blue and got very blue. Some time later, a man in a dark outfit came up, placed his fingers on Mr. Dziekanski's neck as though he were checking his pulse (but did not put his face near Mr. Dziekanski's face) and then walked away. After the firefighters and paramedics had arrived and the handcuffs were removed and Mr. Dziekanski was rolled over, "[H]e was lifeless. They had to assist him in everything. There was no movement at all."[43]

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[41] Transcript, February 4, 2009, p. 87.

[42] Transcript, February 5, 2009, p. 37.

Ms. Kula agreed that she called 911 because she did not think that Mr. Dziekanski should be in the semi-secure International Reception Lounge, and in light of his throwing the wooden table against the glass doors and breaking it, he was a hazard to Airport property – she did not think he was a hazard to the public. She also agreed that she considered going back through the lounge into the Customs Hall, in order to access her computer to see if she could find an interpreter. However, Mr. Dziekanski was holding his suitcases and moving them to block anyone from getting through the swinging glass doors, and she did not want to aggravate him. Although she testified that his smashing of the computer and wooden table caused her concern and alarm, and she did not want to encroach on his area, she also told me that she did not fear him – if he had wanted to hurt her, he could have thrown the chair at her.

Genevieve Deziel, an Alaska/Horizon Airlines customer service agent, described many of the same events as Ms. Kula.[44] She told me that within a minute of being handcuffed, Mr. Dziekanski's face turned from white to blue, and his hands turned blue. She agreed that in her statements to the police, she had described Mr. Dziekanski's handling of the chairs as "aggressive" and that she had called 911 so that some authority figure would come and help Mr. Dziekanski out. She told me that when the officers first arrived, they used their hands and gestures to try to get him to calm down and to control the situation.

Robert Jorssen arrived at the International Arrivals area at about 1:27 a.m. to meet a relative who was arriving on the Cathay Pacific flight from New York.[45] Mr. Dziekanski was, before the police arrived, red in the face, very agitated, and very upset. When the officers arrived, they walked casually toward the swinging glass doors. In response to their arrival, Mr. Dziekanski stepped back toward the counter. Mr. Jorrsen saw Mr. Dziekanski pick up a black object from the counter. He had it up in the air, did not advance toward the officers, and then moved away. At that point the officer deployed the weapon against him, and Mr. Jorssen heard two deployments before Mr. Dziekanski fell to the ground. At least three officers moved in and struggled with him in order to handcuff his hands behind his back. A few seconds later Mr. Dziekanski stopped making any movement. A man, Mr. Jorsen thought was an officer, moved in and took Mr. Dziekanski's pulse on his neck and wrist (but did not put his face close to Mr. Dziekanski's face), and Mr. Jorssen noticed that Mr. Dziekanski's hands were turning white.

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[43] Transcript, February 6, 2009, p. 12.

[44] See also the testimony of Marija Bosnjak, another Alaska/Horizon Airlines customer service agent: Transcript, February 5, 2009, p. 42*ff*.

[45] Mr. Jorssen is, coincidentally, a civilian employee of the RCMP, and executive director of Corporate Management for the RCMP's "E" Division. He told me that he does not personally know, and has never talked to, any of the four RCMP officers involved in this incident.

C. THE AIRPORT'S OPERATIONS AND SECURITY RESPONSE TO CALLS FOR ASSISTANCE

1. Calling for RCMP and BC Ambulance Service attendance

Douglas Byl, a Securiguard employee working in the Airport Operations Centre, took the call from Mr. Agraviador, the elevator 40 guard, about a man making trouble and throwing chairs in the International Reception Lounge. He told me that Securiguard has a contract with the Vancouver Airport Authority to provide security services throughout the Airport. Patrollers do not carry weapons or restraining devices, and their role is to observe and report, but not to engage physically with a person who is violent or is damaging property. When Mr. Byl receives information about a person acting violently, his normal practice is to inform the Airport Operations Centre staff (they share the same office), which decides whether or not to call the RCMP. **Gregory Sambrook** (the operations shift manager that night), who was present in the centre, told Mr. Byl that he would contact Mr. Byl's Securiguard supervisor, Mr. Enchelmaier.

The Vancouver Airport Authority's airport operations officer on duty during the Dziekanski incident was **Carla Hanson.** Seated near her was **Heather Staller** (acting as baggage and gate scheduler that evening) who assisted her with some of the calls.

Ms. Hanson told me that she first heard about the incident when Mr. Byl (seated behind Ms. Hanson at Securiguard's Security Operations Centre desk) received a radio communication at 1:18 a.m. from the elevator 40 security guard (Mr. Agraviador), who told him that he had received a report that there was a man in the International Reception Lounge throwing chairs and causing trouble. Mr. Sambrook (operations shift manager) and **Bob Ginter** (Airport response coordinator) were standing nearby, and one of them told her not to call the RCMP yet, because they only had third-hand information about the incident. About a minute later Ms. Hanson received a call on an Airport courtesy phone from a woman who told her that there was a man, who didn't seem to speak English, who was really drunk and really aggressive, throwing suitcases and furniture around. The woman described him as a man in his forties or fifties, non-Caucasian, with dark hair, and wearing a white coat.

Ms. Hanson immediately, on her own initiative, called the RCMP (at 1:23 a.m.) and reported that they had an apparently intoxicated 40-year-old male in the International Reception Lounge throwing suitcases and chairs around. He was non-white with dark hair, wearing a white coat, and the woman who had called in was worried that the man was going to hurt someone. The dispatcher said they would be on their way.

Ms. Hanson told me that Messrs. Sambrook and Ginter left the centre to go to the International Reception Lounge. At 1:26 a.m. Ms. Staller called Mr. Ginter to update him, which included the following exchange:

Staller	Just an update from the patrollers down there – apparently he is now breaking computers in the area down there too.
Ginter	Exciting job for the Gendarmes.
Staller	And apparently the passengers are getting concerned too – he's throwing chairs through glass ... so it may be getting a little dangerous.

At 1:28 a.m. Mr. Ginter sent a radio message back announcing that the RCMP was on the scene. At 1:29 a.m. he sent another message, which Ms. Staller handled:

Ginter	Can you call ambulance they might need that, the gentleman has been TASERed by the RCMP.

Staller Copy. Bob, do you want us to let ERS [the Airport's Emergency Response Services] know or no just give ambulance a call?
Ginter Just ambulance.[46]

At 1:31 a.m. Ms. Hanson called the BC Ambulance Service, requesting that they attend in response to an intoxicated male in his fifties who had been throwing stuff with glass, and had been TASERed. When she asked if they would be sending one unit on a routine call, the Ambulance Service asked for confirmation that he was conscious and breathing. Ms. Hanson radioed Mr. Ginter, who told her that he understood that the man was conscious and breathing, adding, "We're just getting a head start on things. I don't know if we are going to need it or not, but I think they might."[47] Ms. Hanson relayed to the Ambulance Service that the man was conscious and breathing. Ms. Hanson told me that it was her duty to call Emergency Response Services in the case of a Code 3 emergency, but not for a routine ambulance call like this.

At 1:35 a.m. the BC Ambulance Service phoned Ms. Hanson and advised her that, because the police on the scene were saying that the man was now unconscious, they were upgrading the call to Code 3 and were sending two units, and the fire department was responding as well. Seconds later, Ms. Hanson and Mr. Ginter had the following radio exchange:

Ginter Can you check with maintenance to see if anyone speaks Polish?
Hanson Yes, actually I think they do, but just so you know, ambulance has upgraded it, so I don't know if you guys want to turn down your radios before I do an announcement [i.e., for Emergency Response Services to respond].

Ginter Don't do an announcement; just have ambulance come.
Hanson Is Greg [i.e., Mr. Sambrook] OK with that 'cause they did just say that it was a Code 3?

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[46] Exhibit 26, p. 14.

[47] Exhibit 26, p. 16.

Ginter	Yeah, we're fine.
Hanson	Roger.[48]

Ms. Hanson told me that she was surprised by Mr. Ginter's instruction not to call Emergency Response Services – when a call is upgraded to Code 3, her understanding was that she was required to dispatch Emergency Response Services. That was why she asked "Is Greg OK with that?" and when there was a little pause before Mr. Ginter responded, "Yeah, we're fine," she took that to be Mr. Ginter talking to Mr. Sambrook.

Ms. Staller was asked about a series of e-mails she exchanged with Andrew Caldwell, the acting supervisor of the Airport's Emergency Response Services, during the Dziekanski incident. I think it is fair to characterize these e-mails as primarily personal in nature, not official communications between the Airport's Operations Centre and Emergency Response Services. However, I make reference to them because they show that Emergency Response Services was aware of the incident as it unfolded and was apparently ready and able to respond if called upon to do so. The relevant e-mail exchanges are as follows:

Staller	(1:26 a.m.) There is a report of a guy in the IRL [International Reception Lounge] right now going crazy throwing chairs and suitcases.
Caldwell	(1:28 a.m.) Thanks for the info.... Keep me posted.
Staller	(1:29 a.m.) Sounds like we have a good one on our hands now ... passengers are hiding from this guy he is breaking glass and throwing chairs at people and breaking computer screens! Greg [Sambrook] and Bob [Ginter] are down there.
Caldwell	(1:30 a.m.) Let us know if anyone gets hurt.
Staller	(1:31 a.m.) Calling BCAS [BC Ambulance Service] right now ... the guy was just TASERed by the RCMP.
Caldwell	(1:31 a.m.) Is that Code 3?
Staller	(1:32 a.m.) Bob [Ginter] just asked Carla [Hanson] to call BCAS, she is on the phone right now.... so no not Code 3 it's routine right now.

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[48] Exhibit 26, p. 22.

Caldwell (1:32 a.m.) Thanks for the heads up.
Staller (1:37 a.m.) Here it comes Code 3.

Staller (1:38 a.m.) Stand by.... There isn't going to be a Code 3 call ... sorry.

Ms. Staller told me that she alerted Mr. Caldwell, as a courtesy, that the ambulance call had been upgraded to a Code 3: "I was just letting him know while Carla was still on the phone, get their equipment and get ready to go as a courtesy to a coworker,"[49] because she fully expected that Emergency Response Services would be sent to the scene. She was surprised when they were not called. She told me that she and Ms. Hanson both agreed that it would be wise to get Mr. Sambrook to confirm the decision not to call out Emergency Response Services.

Ms. Staller told me that if the Airport Operations Centre is notified that a passenger has passed out or has suffered a heart attack, the protocol requires her to first call the BC Ambulance Service. She must wait until BC Ambulance Service designates it as a Code 3 before she is allowed to alert the Airport's Emergency Response Services.

Ms. Hanson's understanding was slightly different. While she agreed that her instructions in October 2007 were not to call Emergency Response Services for routine medical matters, she went on:

Q Did you have discretion to call ERS for routine medical if you thought it was appropriate?
A It's not unheard of. It is possible.[50]

2. Attendance at the International Reception Lounge

Lance Rudek, a Securiguard patroller, is seen on the Airport closed-circuit video coming down the escalator into the public Meeting Area at 1:26 a.m., with a colleague, **Sidharth Arora**.[51] He was unable to communicate with Mr. Dziekanski, who appeared very stressed, very sweaty, and very pale. When he told Mr. Dziekanski to put things down, Mr. Dziekanski gave him a dead stare. Mr. Dziekanski threw a computer on the ground, and when Mr. Rudek tried to get him to calm down, Mr. Dziekanski picked up a small folding wooden table and threw it against a window, breaking the table. He realized that the RCMP was on the way and he decided that, as long as Mr. Dziekanski was alone in the International Reception Lounge and was not hurting anyone, he would not intervene. At the same time, his main concern was the security of people and the facility. He was hesitant to go into the lounge where Mr. Dziekanski was. He told me he would not be comfortable if Mr. Dziekanski came out of the lounge. When the RCMP arrived, Mr. Rudek told one of them, as they were walking toward the swinging glass doors, that the man did not speak English, and the officer nodded.

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[49] Transcript, February 12, 2009, p. 8.

[50] Transcript, February 11, 2009, p. 38.

[51] Mr. Arora did not have as detailed a recollection of events as did Mr. Rudek, but his testimony was generally consistent with Mr. Rudek's testimony.

Mr. Rudek saw the officers make hand gestures that he interpreted to mean that they were trying to get Mr. Dziekanski to calm down. He thought they were trying to defuse the situation. Mr. Dziekanski had a stapler in his hand. He waved it around at the officers. He then held it out directly in front of him and started pressing it and staples started coming out (or he made an attempt to squeeze the staples out). Mr. Dziekanski backed up, which Mr. Rudek interpreted as backing off to make space or to put up a fight. Moments later, the conducted energy weapon was used against Mr. Dziekanski. As the officers were restraining Mr. Dziekanski, Mr. Rudek saw him lying on his stomach on the floor with his head turned and his hands cuffed behind his back. When the officers moved away from Mr. Dziekanski, Mr. Rudek saw that Mr. Dziekanski's hands looked a little reddish or bluish.

Mr. Rudek was aware that a Cathay Pacific flight was scheduled to arrive soon. He left the scene and went into the Customs Hall, to advise people working there that there was an incident in the International Reception Lounge which arriving passengers should not see, and that they should either be held in the Customs Hall or re-routed elsewhere. When he returned to the scene, Richmond firefighters were there.

Fabian D'Sa was the third Securiguard patroller on duty during the Dziekanski incident. The RCMP officers were already on the scene when he arrived at the

International Terminal's public Meeting Area. He walked up to the swinging glass doors, and saw Mr. Dziekanski on the ground with three police officers on top of him:

> Q Okay. So you saw him on the ground. When you first saw him, where were the police officers?
>
> A One had his back towards me and his one knee on Mr. Dziekanski's neck. The second person was – two other officers were facing me. One near his head, holding his shoulder down as well on the other side, and the third officer was trying to handcuff him.[52]

Mr. D'Sa moved into the International Reception Lounge. Mr. Dziekanski was, based on Mr. D'Sa's previous training, in a takedown position, and one officer had his knee on Mr. Dziekanski's neck and back area on the right-hand side. He was on his stomach and was resisting attempts to handcuff him, but there was not as much activity as earlier. Mr. D'Sa then went outside the terminal to meet the Richmond Fire Department and BC Ambulance Service units. He told me that he was familiar with the Airport's Emergency Response Services, and was surprised that they were not at the scene.

Trevor Enchelmaier, Securiguard's shift manager, told me that he arrived at the International Terminal's public Meeting Area at about 1:29 a.m. He entered the International Reception Lounge through the swinging glass doors. He saw four RCMP officers, with Mr. Dziekanski on his stomach on the ground and with his hands cuffed behind his back. Mr. Dziekanski was flailing his legs around and banging them extremely hard on the ground, and Mr. Enchelmaier thought it must have been hurting him. To prevent him from hurting himself or kicking other people, Mr. Enchelmaier moved in, trapped Mr. Dziekanski's legs with his legs, and held them with his hands. He heard one of the officers say something like "he's out of it," and he realized that Mr. Dziekanski had stopped kicking, so he released his legs and stood up.
Mr. Dziekanski was not moving at this time, and Mr. Enchelmaier did not observe him make any movements subsequently. Mr. Enchelmaier gave the following testimony about Cpl. Robinson's actions, when Mr. Dziekanski stopped moving:

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[52] Transcript, February 16, 2009, pp. 49-50.

Q I'm going to suggest to you that your memory is that Corporal Robinson, when Mr. Dziekanski stopped moving, he was right beside Mr. Dziekanski, leaning over and conducting an assessment of him.

A Yes, sir.

Q And that remained consistent until a higher level of responders attended, that is the Fire.

A To my recollection, yes, best of my recollection.

Q All right. And you say to your recollection. I take it, though you were busy with tasks, you always had some attention on Mr. Dziekanski to ensure that he was being properly cared for, consistent with your level of training?

A Whenever I looked over in that area, there was always an officer there.

Q All right. And I'm going to suggest to you that officer was always Corporal Robinson.

A That's – yes, that's correct.[53]

Mr. Dziekanski was lying on his stomach with his legs straight out behind him, with his hands cuffed behind his back. The officers seemed concerned as to whether Mr. Dziekanski was conscious. Mr. Enchelmaier told me that within seconds of Mr. Dziekanski going unconscious, Cpl. Robinson (with Mr. Enchelmaier's assistance) moved Mr. Dziekanski into the recovery position, which meant rolling him partially onto his side, with one leg up and his head turned to the side. Because of the handcuffs, his hands and arms could not be repositioned. At about this time (Mr. Enchelmaier could not remember if it was before or after Mr. Dziekanski was placed in the partial recovery position), Mr. Enchelmaier heard one of the RCMP officers call dispatch to upgrade the ambulance call to Code 3. He also observed Cpl. Robinson check Mr. Dziekanski's carotid pulse (with his gloves on, which Mr. Enchelmaier knew would not be very effective) and check whether Mr. Dziekanski was breathing, by placing his ear close to Mr. Dziekanski's mouth and checking his chest.

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[53] Transcript, February 17, 2009, p. 41.

Mr. Enchelmaier, who was trained in first aid, knelt down behind Mr. Dziekanski's neck and checked his carotid artery for a pulse for possibly 10 seconds. He felt a very strong, fast pulse, like you would expect from someone who had been running. He told Cpl. Robinson that he could feel a pulse, and Cpl. Robinson confirmed that he heard breathing. It appeared clear that Mr. Dziekanski was unconscious.

According to Mr. Enchelmaier, he checked Mr. Dziekanski's carotid artery again several minutes later for a pulse. When asked for how long, he stated, "Possibly the same again, 10 to 20 seconds possibly."[54] This time the pulse was still strong, but slower, as you would expect with a person at rest. He also checked his breathing by placing his ear several inches from Mr. Dziekanski's mouth, and by observing his chest. It was not heavy breathing, but was consistent with a person at rest. He did not see any movement by Mr. Dziekanski. He confirmed these findings with Cpl. Robinson.

He testified that several minutes later, about two minutes before the firefighters arrived, he checked Mr. Dziekanski again for approximately the same amount of time: 20-30 seconds. His carotid pulse was clear and slow, and his breathing was slow, low breathing. Mr. Dziekanski's eyes were closed throughout his dealings with him. Mr. Enchelmaier told me that it took 10-30 seconds to take each pulse, and each pulse had a regular rhythm. When the firefighters arrived they asked the officers to remove the handcuffs, but they were not removed. It was only when the Ambulance Service arrived and emphatically requested removal a second time that they were removed. It was also only after the firefighters and BC Ambulance Service arrived that Mr. Enchelmaier noticed a change in Mr. Dziekanski's colour – going from blue to a grey colour.

3. The decision not to dispatch Emergency Response Services

Robert Ginter, the Airport response coordinator on duty that night, described his responsibilities as follows:

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[54] Transcript, February 16, 2009, pp. 92-93.

> [T]o oversee the operation of the entire Airport, both airside, groundside and in the terminal building. There were regulatory requirements that we were to do, inspections that we have to undertake. It was also to be out and about, to respond to operational concerns and to represent the Airport to resolve those concerns, whether it be a safety issue, an equipment breakdown, a customer service concern, security incident, aircraft emergency. It was sort of an all-encompassing role.[55]

He was in the Airport Operations Centre when Mr. Byl received what Mr. Ginter considered a very confusing call from the elevator 40 guard, about a disturbance in the International Terminal Building. Ms. Hanson was hesitant to call the RCMP until she had more detailed information. Mr. Ginter instructed her not to call the RCMP, but to wait for a moment, expecting that additional calls with more information would come in. Moments later another call came in with more detailed information indicating violence, and she called the RCMP. Mr. Ginter went into the office of the operations shift manager (Mr. Sambrook) and explained the situation, and the two of them left the Operations Centre to go down to the International Reception Lounge. En route, Mr. Sambrook called Mr. Enchelmaier to ensure that security personnel had been dispatched, and they also received an update that the man was attempting to throw chairs through the glass wall, breaking things.

When they reached the top of the escalators (at 1:28 a.m.), they saw the RCMP officers arriving and going into the International Reception Lounge. Messrs. Ginter and Sambrook stayed outside the lounge, but could see what was happening inside the lounge. Mr. Dziekanski was very irritated, and the RCMP officers were trying to calm him down. He moved suddenly to his right and made a motion across the tourism information counter. Mr. Ginter saw a black object in Mr. Dziekanski's hand, which he appeared to be waving; Mr. Sambrook thought it might be a knife. It was his recollection that after grabbing the item Mr. Dziekanski moved toward the RCMP officers. Shortly thereafter, Mr. Ginter heard the crackling sound of the conducted energy weapon. The four officers were engaged with Mr. Dziekanski, trying to hold him down, pin his arms, and put handcuffs on. The weapon did not seem to incapacitate Mr. Dziekanski, who was extremely active and very vocal, and who appeared to be the aggressor. Mr. Ginter told me that he had never seen anything remotely close to this before. It was a traumatic visual experience, and he was stunned.

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[55] Transcript, February 17, 2009, p. 49.

At 1:29 a.m. Mr. Ginter radioed the Operations Centre, and asked Ms. Staller to call an ambulance as a precautionary measure. He explained why:

> Both the potential for a medical problem and the violent nature of the confrontation. I assumed, given the violent nature of the confrontation, that the RCMP would want medical assistance to do an assessment prior to taking the person into custody.[56]

He told me that he decided not to dispatch the Airport's Emergency Response Services because of the violence (this was the most violent thing he had ever seen), which made it an unsafe site.

At 1:32 a.m. Mr. Ginter moved into the International Reception Lounge to assess the situation, having formed the opinion that the RCMP officers had Mr. Dziekanski under control and that it was safe to enter. He wanted to assess property damage and was concerned about the imminent arrival of the Cathay Pacific flight that was due in at 1:30 a.m. Several minutes later, Mr. Enchelmaier told him that Mr. Dziekanski had a pulse and was breathing, but had lost consciousness. Mr. Ginter thought otherwise. In his view he was still conscious, but had simply surrendered to the officers realizing that he was now in custody. He did not make any further observations of Mr. Dziekanski, because Mr. Dziekanski was under the care and control of the RCMP officers.

At 1:37 a.m., having just heard that the incident had been raised to Code 3, Ms. Hanson called Mr. Ginter. He had just learned from one of the RCMP officers that they had determined through documentation that Mr. Dziekanski was Polish, so he asked her to check with maintenance to see if anyone spoke Polish. She said she would, and their conversation continued:

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[56] Transcript, February 17, 2009, pp. 76-77.

Hanson	Just so you know, ambulance has upgraded it, so I don't know if you guys want to turn down your radios before I do an announcement.
Ginter	Don't do an announcement, just have ambulance come.
Hanson	Is Greg OK with that 'cause they did just say that it was a Code 3?
Ginter	Yeah we're fine.[57]

Mr. Ginter told me that the announcement Ms. Hanson intended to give would have been broadcast to everyone with radios, advising them of the situation and location. It would have meant that there was a Code 3, which would have meant that the Airport's Emergency Response Services would have been dispatched. He did not hear the RCMP radio call that Mr. Dziekanski was unconscious and to upgrade the ambulance call to Code 3, he did not know why the call had been upgraded and he did not enquire as to the reason for the upgrade, as shown in the following exchange:

Q	Were you at all curious as to why the call had been upgraded?
A	I was – I don't know if curious is the right word, but it seemed strange to me given the circumstances, the calm nature of the scene, the people going about their business, no sense of any indication of medical distress by anyone on scene.
Q	Had you seen anybody interacting with Mr. Dziekanski?
A	The RCMP were – every time I observed Mr. Dziekanski, the RCMP were monitoring him.
Q	Did you see any RCMP officer appear to check his pulse or breathing at any point?
A	I never – I did not observe that.
Q	Did you see any other person appear to check his pulse or breathing at any point?
A	I did not.[58]

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[57] Exhibit 26, p. 22.

[58] Transcript, February 17, 2009, p. 84.

He agreed that by instructing Ms. Hanson not to make an announcement, he was effectively telling her not to dispatch Emergency Response Services. It was a quick decision. The situation appeared to be under control and an ambulance was on the way, and from his experience, the response time of the Richmond Fire Department (which would be responding to the Code 3) was very similar to that of Emergency Response Services. He told me that when Emergency Response Services responds to a call in the International Terminal Building, they must drive across the main apron, park at aircraft Gate 52, and walk across the roadway and down a path to a secure door into the building. They cannot open that door and have to wait for security people to release the door and then, once inside, ensure that the door is secure again. He added:

> And it's in context of my role as an Airport Response Coordinator, is to take a large overview. From the outset I considered this a police incident of a violent nature, that the response was initiated for medical assistance. We had virtually our entire Security Department and Operations Department on scene. And the situation appeared to be under control. So when the call came to upgrade, I felt I had – we had all our resources here. There was nothing left behind if ERS came as well. We would not have the ability to respond to any additional potential incident that may occur....
>
> If there was to be another medical call, if there was to be a fire alarm, if there was to be an aircraft incident, we were all at one location. And part of what the role of the Response Coordinator was to try and keep a larger – a view of the larger picture, to make sure you had the appropriate resources responding but don't undermine the safety and security of the rest of the Airport.[59]

Mr. Ginter acknowledged that the Airport had a mandatory standing order that Emergency Response Services be dispatched when there was a Code 3 medical and that the policy does not specifically give him discretion not to dispatch. He told me that there would have been at least four members on duty at Emergency Response Services that morning, and that when they respond to a Code 3 medical emergency they typically send two members.

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[59] Transcript, February 17, 2009, p. 85.

Mr. Ginter was also asked whether he checked with Mr. Sambrook, before ordering Ms. Hanson not to make an announcement:

Q	You were asked about Mr. Sambrook. Do you actually speak with him in that slight pause we hear between the question, "Is Greg OK with that?"
A	I did not.
Q	Did you know if Greg was okay with that?
A	I did not ask him. I don't know.
Q	So when you say, yes, we're fine, what you meant is yes, I'm fine?
A	"We're" as in the scene is fine.[60]

Mr. Ginter agreed that the Airport's medical emergency standing order required him to obtain the automated external defibrillator in response to any Code 3. He did not do so in this case and explained his reasons:

Q	Did you make any attempt at all to get an AED brought to the area where Mr. Dziekanski was?
A	I did not. My training on the AED, it was made very explicit to me that the AED was only of use – was used on certain circumstances which was referred to as Code Blue by the instructor. That's someone who is unconscious and no pulse. I believed Mr. Dziekanski was conscious and never considered the AED.
Q	Did it cross your mind that it might be a precautionary measure in case the situation deteriorated?
A	It did not cross my mind.[61]

Mr. Ginter told me that it was only about one minute before arrival of the Richmond Fire Department that he realized that Mr. Dziekanski was unconscious. He stated:

Q	When you realized that Mr. Dziekanski was unconscious, what was your first thought?
A	Holy shit.

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[60] Transcript, February 17, 2009, p. 87.

[61] Transcript, February 17, 2009, p. 96.

> Q And why – why did you feel that?
> A Because of the call I'd made previously about not having ERS respond.
>
> Q Okay. And you've had that thought more than once since then.
> A More than once. I've relived this many a time.

The first thing Mr. Ginter did was go curbside to make sure that there was no impediment or barrier to the arrival of the firefighters, and to ensure that the security escort was there. When he heard the sirens, he felt a great sense of relief.

At 1:44 a.m. Mr. Caldwell from the Airport's Emergency Response Services called Mr. Ginter, enquiring whether the Richmond Fire Department was on scene for a Code 3 medical. Mr. Ginter responded, confirming that it was, for a police incident. Mr. Caldwell asked Mr. Ginter to call him on his cell phone when he had a chance, and Mr. Ginter agreed to do so. Mr. Ginter summarized the conversation that they had when he called Mr. Caldwell back:

> During that conversation, Mr. Caldwell was frustrated that he had not been called – called out because of the medical. I discussed with him that it was a police incident, and he was obviously frustrated and didn't understand why he wasn't called.[62]

Andrew Caldwell was the acting supervisor at the Airport fire hall during the Dziekanski incident. He told me that Emergency Response Services was established in 2004. They provide firefighting and medical first response, as well as snow clearing, grass cutting, and general airfield maintenance. They are trained to the same standards as the Vancouver and other Lower Mainland fire departments, with additional training specific to airside aircraft emergencies. There is a minimum of five members on duty at any time, who rotate duties – three to drive the emergency vehicles and two for medical response. Personally, Mr. Caldwell is trained as a Level 2 firefighter and as a Level 3 first responder with a spinal endorsement and an automated external defibrillator endorsement. He is trained in, and instructs in, cardiopulmonary resuscitation.

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[62] Transcript, February 18, 2009, p. 2.

He told me that there were five members on duty that night. They normally respond only to Code 3 calls, but will respond to routine calls if dispatched. They are always dispatched when a Code 3 is declared – he could not recall any other Code 3 incident when Emergency Response Services was not called out. In a timed test, they were able to reach the International Reception Lounge four minutes and twenty seconds after receiving the dispatch. On that route, they have to go through a primary security line door at Gate 52, which means having to call the Security Centre, where someone can unlock the electronic magnetic lock remotely. Sometimes there can be delays in getting this door opened.

On this night, he learned that a Code 3 had been declared. His group was anticipating being called out, and they were ready. He described the conversation he later had with Mr. Ginter:

> When he phoned me on the cell phone, he – I asked him why we hadn't been called out. He told me on the telephone that, based on his assessment at the scene, more responders weren't required, and he sounded quite remorseful and upset at what he had just witnessed. So at that point, I just asked if he was okay and if he needed anything from us, and that we would take care of any responsibilities or anything that came up in the airfield later on for the rest of that shift.[63]

Mr. Caldwell told me that the worst thing that can happen to trained emergency responders is not getting an opportunity to make a difference in an area that they are responsible for. He added that in this instance, "Nobody believed they could have made a difference. I believe we all would like the opportunity to try and make a difference."[64]

Gregory Sambrook was the senior Airport Operations official on duty that night, serving as operations shift manager. He overheard Ms. Hanson's phone conversation about a disturbance, and he accompanied Mr. Ginter down to the International Reception Lounge. It was late at night, and because he had heard about throwing chairs, breaking glass, and a disturbance, he thought something dangerous might be happening and he wanted to make sure that Mr. Ginter would be safe. As they descended the escalator he saw Cpl. Robinson and other RCMP officers arriving at the International Terminal's public Meeting Area. He initially went into the waiting area, then hopped over the railing and stood by the swinging glass doors for three to five minutes, to prevent anyone from entering the International Reception Lounge. At about this time he and Mr. Ginter had a conversation in which they agreed that Emergency Response Services should not attend. When asked why, Mr. Sambrook told me, "Safety and security. This was a police situation. There wasn't a need to have ERS there and if ERS did attend, what would happen if they got hurt?"[65]

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[63] Transcript, February 18, 2009, p. 74.

[64] Transcript, February 18, 2009, p. 79.

Mr. Sambrook then entered the lounge area, where he saw Mr. Dziekanski on the ground handcuffed, moaning and making noises. He considered this to be a crime scene, and began thinking about how it would impact on Airport operations. He walked through the lounge into the Customs Hall and told officers there to re-route arriving passengers, and he then returned to the lounge.

Mr. Sambrook knew that an ambulance had been called, but he did not realize that it had been upgraded to Code 3 until he saw the Richmond Fire Department crew arrive. This surprised him, because he thought that the situation was under control. He had no recollection of hearing Mr. Ginter tell Ms. Hanson not to make an announcement that would have dispatched Emergency Response Services, and had no recollection of Mr. Ginter consulting him before Mr. Ginter told Ms. Hanson, "Yeah we're fine." He did not realize, until after the Richmond Fire Department left the scene, that Emergency Response Services had not been dispatched. He was asked whether Mr. Ginter had the authority to override the medical emergency protocol:

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[65] Transcript, April 14, 2009, p. 54.

Q	The question is, did Mr. Ginter, given his position, have the authority alone to override the standing orders set out in "Medical Emergency?"
A	It was my understanding, in the position Mr. Ginter was in, that he could supercede that if he thought it was necessary, using his field judgment based on the decisions of safety and security of the area, himself and anything else that may be brought into the decision-making process.[66]

Contrary to Mr. Caldwell's recollection, Mr. Sambrook told me that he could recall other instances when Emergency Response Services did not respond to Code 3 medicals, but could not recall specifics. In his view, on this night they were dealing with a police scene that the police were managing, and he did not see a need for him to make a call to have Emergency Response Services attend. He supported Mr. Ginter's decision.[67] However, he adopted what he had told an RCMP investigator later – that he regretted that Emergency Response Services was not called.

Mr. Sambrook was asked about the policy requiring a person in Mr. Ginter's position to bring an automated external defibrillator to Code 3 medical calls, or arrange for one to be brought.[68] He did not recall one being brought to the scene in this case, nor did he recall any discussion about it. He thought that, in October 2007, a defibrillator would have been stored at the International Terminal's information counter at the top of the escalators.

Karol Vrba, an Airport airfield operational specialist stationed at the Airport fire hall, told me that he went up to the Airport Operations Centre sometime after 1:00 a.m. to obtain a form he required in order to record which aircraft were berthed overnight at the Airport. When he entered the centre, Carla Hanson was speaking on the telephone. He obtained the form from Heather Staller and asked what was going on. Ms. Staller told him that there was a man, probably speaking Russian or some other language, in the International Terminal causing a disturbance. He responded: "You know I speak Russian. So if you need me, you can reach me on my radio."[69] She told him not to worry about it, and to carry on with his recording of aircraft.

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[66] Transcript, April 14, 2009, p. 45.

[67] According to the "Medical Emergency" section of the Airport's *Emergency Management Plan* (Exhibit 83), the Operations Officer's duty in the case of a medical emergency is to call the BC Ambulance Service and, when that emergency involves a Code 3 ill person, to call Emergency Response Services. For Code 3 medical emergencies, the supervisor of Emergency Response Services "will determine whether ERS will provide a first response" (p. 4).

[68] According to the "Medical Emergency" section of the Airport's *Emergency Management Plan* (Exhibit 83), it is the duty of the Airside or Terminal Duty Manager to respond with an automated external defibrillator to Code 3 medical calls, or to arrange for a defibrillator to be brought to the location of the ill person (p. 6).

After Mr. Vrba completed his recording of aircraft, he returned to the Airport Operations Centre at around 2:00 a.m. He saw that people were overwhelmed and shocked. When he asked what was going on, they told him that Mr. Dziekanski was TASERed and had died. He told them: "Why didn't you call me on my radio? I told you I can help."[70] He stayed there talking about the incident for about an hour and then went back to the fire hall. He told the crew there what had happened. They were all shocked, because it appeared to him that no one knew anything about the Dziekanski incident.

Ms. Hanson and Ms. Staller both told me that they had no recollection of Mr. Vrba coming into the Operations Centre to pick up an aircraft parking form that morning, but did remember him coming in later to drop off the completed form.

D. FINDINGS OF FACT AND CONCLUSIONS

Before making any findings of fact or reaching any conclusions, I gave careful consideration to the written and oral closing submissions of counsel for the participants. Having done so, I reached several conclusions.

First, the initial closed-circuit video record we have of Mr. Dziekanski after he was allowed to enter Canada was taken at 12:54 a.m., up to 14 minutes after he cleared the Point. He is seen pushing his suitcases in a luggage cart through the swinging doors from the International Reception Lounge into the public Meeting Area. He appears to be looking for someone, presumably his mother. People who interacted with him at this time used various words to describe his behaviours – unusual, upset, nervous, angry, distraught, and bizarre. He was sweating, appeared to be talking to himself, and at one point hit the glass doors with his hands in an attempt to get back into the lounge. He used his suitcases and a chair to form a barrier, and although he made some statements in what we now know to be Polish, he did not respond verbally when people spoke to him, likely because no one communicated to him in Polish. Significantly, none of the people who approached and/or spoke to Mr. Dziekanski felt threatened by him, although several were reluctant to encroach on his "territory." However one characterizes his agitation or frustration, it was not directed at other people.

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[69] Transcript, February 10, 2009, p. 92. In his examination-in-chief, Mr. Vrba testified that he also told her that he spoke Polish, but during cross-examination he told me that the first time he mentioned that he spoke Polish was during a subsequent conversation with her sometime after 2:00 a.m.

[70] Transcript, February 10, 2009, p. 93.

Second, Mr. Dziekanski did, without question, destroy two items of Airport property. The Pritchard video shows him smashing a small folding wooden table against the glass wall adjacent to the swinging glass doors (breaking the table), and throwing a computer monitor on the floor, breaking it.

Third, I commend several members of the public and other people working at the Airport for making an effort to try to communicate with Mr. Dziekanski and calm him down. They could tell he was in distress, and responded with concern and compassion. I particularly acknowledge Ms. Ashrafinia for her actions, her empathy, and her kindness.

Fourth, when I compare the testimony of some of these witnesses to their statements to the RCMP soon after the event, I am left with the impression that they initially perceived Mr. Dziekanski's behaviour as more extreme and perhaps more dangerous. Their view of events softened by the time they gave evidence at our public hearings, perhaps out of sympathy for Mr. Dziekanski and his untimely death. I credit counsel for several participants, who highlighted these differences during cross-examination, for providing a more complete and balanced view of events. Nevertheless, the evidence satisfies me that these witnesses were neither afraid of nor felt threatened by Mr. Dziekanski.

Fifth, those in the Airport's Operations Centre acted promptly and appropriately in ascertaining the nature of the disturbance in the International Reception Lounge, in calling the RCMP for assistance, and in dispatching security personnel to the area. The security personnel who attended the scene acted in accordance with their limited mandate to "observe and report."

Sixth, the Airport Authority's airport response coordinator, Robert Ginter, candidly acknowledged in testimony that when he saw Cst. Millington deploy the conducted energy weapon against Mr. Dziekanski, it was a traumatic visual experience and he was stunned. Nevertheless, he promptly recovered enough to radio the Operations Centre and ask Ms. Staller to call an ambulance as a precautionary measure. I commend him for doing so.

Seventh, I cannot be so complimentary respecting his decision not to dispatch the Airport's Emergency Response Services. After the RCMP officers realized that Mr. Dziekanski had lapsed into unconsciousness and requested that the ambulance call be upgraded to Code 3, Ms. Hanson conveyed this information to Mr. Ginter, and told him that (in accordance with Airport policy) she was about to make a Code 3 announcement that would automatically result in Emergency Response Services being dispatched to the scene. He told her not to make the Code 3 announcement. Ms. Hanson expressed surprise at this and asked him, "Is Greg OK with that 'cause they did just say that it was a Code 3?" Mr. Ginter paused and then replied, "Yeah we're fine." Ms. Hanson told me that this pause and his response, "we're fine" satisfied her that Mr. Ginter had conferred with Mr. Sambrook. I am satisfied that when Mr. Ginter said "we're fine," he intended to cause Ms. Hanson to believe that he had conferred with Mr. Sambrook and that the two of them were in agreement not to dispatch Emergency Response Services. I do not accept Mr. Ginter's testimony that when he said "we're fine," he meant "the scene is fine."

In his testimony, Mr. Ginter told me that he did not confer with Mr. Sambrook before saying "we're fine," and acknowledged that he was solely responsible for the decision. He advanced several reasons for his decision: this was a violent incident and a potentially unsafe site, the incident was now under control, an ambulance was already on the way, and the response time of Emergency Response Services and the Richmond Fire Department would have been about equal. Finally, he told me that if Emergency Response Services attended, virtually all of the Airport Authority's resources would be at one scene, without the ability to respond to another medical, fire, or aircraft emergency.

I find none of his explanations convincing or even credible. With four RCMP officers on the scene dealing with Mr. Dziekanski, it is difficult to see how the safety of Emergency Response Services was at risk, and even if it was, that hardly justifies his decision to keep them entirely away from the scene of a Code 3 medical emergency. Mr. Ginter did not have the same concerns for safety when he called for an ambulance to attend.

His other explanations imply his belief that he had discretion not to dispatch Emergency Response Services in the face of a Code 3 medical emergency. He acknowledged that the written policy did not explicitly grant him discretion. I conclude that he improperly directed Ms. Hanson not to dispatch Emergency Response Services, when he knew or should have known that he had no discretion to override the written policy.

I am particularly troubled by his explanation that calling out Emergency Response Services to this incident would leave the Airport unable to respond to another medical, fire, or aircraft emergency. That is inconsistent with his own knowledge that Emergency Response Services had at least four personnel on duty at any time and that only two would respond to this type of call. Of even more concern is the rationale behind this explanation – don't dispatch Emergency Response Services to a call because, if you do so, there will be no capacity to respond to another call. If that were the operative principle, Emergency Response Services could *never* be dispatched. In short, Emergency Response Services were ready, willing, and able to respond to this Code 3 medical emergency, and were highly qualified first responders. I cannot say whether the outcome would have been different had they been promptly dispatched,[71] but I do share Mr. Caldwell's sentiment that in an emergency they would like to try to make a difference.

Before moving on, I want to make an additional observation about whether a person in Mr. Ginter's position had discretion to override the written Airport policy in a Code 3 medical emergency situation. Notwithstanding Mr. Ehrenholz's policy testimony to the contrary, I am firmly of the view that no such discretion existed at that time. The policy did not specifically give the Airport response coordinator any such discretion, but *did* give discretion to the supervisor of Emergency Response Services (e.g., Mr. Caldwell) as set out in Exhibit 83, p. 4. This was, in my view, a sound policy. Upgrading a routine ambulance call to Code 3 is a decision properly left to medical professionals – in this case the RCMP officers requested an upgrade and the BC Ambulance Service made the upgrade based on the medical symptoms described to them. Once a Code 3 has been announced, a lay employee of the Airport should have no authority to override that medical decision, as Mr. Ginter did in this case. Dispatching Emergency Response Services should be automatic, and only someone with appropriate medical qualifications should have the authority to override that dispatch. The Airport's written policy gave that discretion to the supervisor of Emergency Response Services where, in my view, it properly rested. Even if Mr. Ginter did have the discretion to override the written policy, I am satisfied that Mr. Ginter unreasonably exercised his discretion.

Eighth, Mr. Ginter told me that it did not cross his mind to obtain an automated external defibrillator after the call was upgraded to Code 3, even though he was aware that the Airport's emergency medical standing order required him to do so, or to arrange for a defibrillator to be brought to the scene. He told me that his training made it very explicit that a defibrillator was only of use when someone is unconscious and has no pulse, and he added: "I believed Mr. Dziekanski was conscious and never considered the AED." I fault Mr. Ginter's response for the following reasons – he had no discretion to override the Airport policy, he had no reason to disagree with Mr. Enchelmaier's assessment that Mr. Dziekanski was unconscious, and in any event it was not up to him to make a medical assessment. The policy is clear that an automated external defibrillator must be brought to the scene of *all* Code 3 medical calls. It is not up to a layperson in Mr. Ginter's position to make a medical assessment as to whether a defibrillator is needed, but simply to take steps to get one to the scene. In my view, the policy is sound. Hopefully a defibrillator will not be needed, but if it is, seconds count, and it is far better to have one already on the scene if the patient goes into fibrillation. If Mr. Ginter had acted promptly, a defibrillator might have been on the scene several minutes before the first firefighters arrived.[72]

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[71] Ms. Hanson advised Mr. Ginter of the upgrade to Code 3 at 1:37 a.m. Mr. Caldwell testified that on a test run it took 4:20 to reach the International Reception Lounge after receiving a dispatch, which would mean that in this incident they might have arrived by 1:41:20 a.m. The first firefighters arrived curbside at 1:41:36 a.m.

Ninth, Mr. Sambrook told me that he had no recollection of Mr. Ginter telling Ms. Hanson not to dispatch Emergency Response Services; indeed, he did not know that the call had been upgraded to Code 3 until he saw the Richmond Fire-Rescue crew arrive. He told me that in his view Mr. Ginter had discretion (using his field judgement) not to dispatch Emergency Response Services in a Code 3 medical emergency, and he supported Mr. Ginter's decision.

I accept Mr. Sambrook's testimony that he did not know, until the firefighters arrived, that the call had been upgraded to Code 3. That being so, the only question that remains is whether he should have played a more hands-on role in supervising Mr. Ginter's response to the event. In other words, if he had stayed with Mr. Ginter, he would have been in a position to learn that a Code 3 had been called, and then to decide whether or not to overrule Mr. Ginter's decisions not to dispatch Emergency Response Services and not to obtain an automated external defibrillator.

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[72] Ms. Hanson advised Mr. Ginter at 1:37 a.m. that the call had been upgraded to Code 3. If Mr. Ginter had immediately gone up to the information desk at the top of the escalators (where Mr. Sambrook testified that he believed an automated external defibrillator was stored), he might possibly have brought it back to the scene by 1:40 a.m. The first fire truck arrived curbside at about 1:41:36 a.m.

Based on the evidence before me, I do not think I can impose a duty on Mr. Sambrook to perform such a tight supervisory role. On the one hand, Mr. Sambrook was required to "monitor the incident and ensure a timely response has been initiated."[73] On the other hand, Mr. Ginter was responsible for responding to these types of incidents on behalf of the Airport Authority. In his testimony he accepted that responsibility, and he accepted sole responsibility for the decisions not to dispatch Emergency Response Services and not to obtain a defibrillator. In my view, responsibility and accountability end there. Having said that, I repeat what I said earlier that in my view Mr. Ginter did not have discretion not to dispatch Emergency Response Services in a Code 3 medical emergency. Mr. Sambrook's after-the-fact support for Mr. Ginter's actions in this case indicates a serious misunderstanding of the Airport Authority's written policy on an important matter.

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[73] Exhibit 83, p. 8.

PART 6

THE RESPONSE OF THE RCMP, RICHMOND FIRE-RESCUE, AND BC AMBULANCE SERVICE

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A. INTRODUCTION

In this part of the report, I will summarize the testimony of each of the four RCMP officers who responded to the call to attend the Vancouver International Airport (in the order in which they testified), followed by the testimony of the officer in charge of the Airport sub-detachment. I will then summarize the testimony of:

- three senior RCMP officers respecting a November 5, 2007, e-mail suggesting that the four officers who attended the Dziekanski incident developed a plan of action en route to the Airport respecting deployment of a conducted energy weapon;
- the Richmond firefighters and BC Ambulance Service paramedics who attended the scene;
- three video analysis experts;
- the officer who downloaded data from the conducted energy weapon used against Mr. Dziekanski;
- the interpreter who translated from Polish into English the statements made by Mr. Dziekanski as captured on the Pritchard video; and
- four use-of-force experts.

Finally, I will set out my findings of fact and conclusions as to what happened, taking into account all of this evidence. Where there is a conflict in the evidence as to what happened, I will indicate which evidence I accept and, wherever possible, my reasons for doing so.

B. THE RCMP OFFICERS

The RCMP, which serves as the municipal police force for the City of Richmond, maintains a sub-detachment at the Vancouver International Airport that provides policing services at the Airport and a nearby small community. On the night of October 13/14, 2007, there were four officers on duty at the sub-detachment – Corporal **Benjamin Monty Robinson** as the officer in charge, and Constables **Gerry Brian Rundel**, **Bill Bentley**, and **Kwesi Millington**.

1. Constable Rundel[74]

a. *Responding to the call for assistance*

At about 1:26 a.m. the four officers were sitting together during a lunch break at the sub-detachment when they received a call from Richmond Dispatch. Dispatch informed them that there was an intoxicated 55-year-old, non-white male at the Arrivals Reception Lobby throwing luggage around. He had dark hair and a white coat. Cst. Millington responded to the call, and the other three officers decided to attend as well.

Each officer drove to the International Terminal separately. En route, they were updated by radio that the male was now throwing chairs through glass windows in the same area. Cst. Rundel told me that he expected, if this information turned out to be true, to arrest the individual.

It took about one minute to reach the International Terminal. All four police vehicles arrived and all four officers entered the building at about the same time. He did not remember any conversation among the officers as they entered the building. While walking through the public Meeting Area, a woman said in a distressed, panicky tone of voice, "He's over there," pointing to where Mr. Dziekanski was, and she or someone else said, "He doesn't speak English." Cst. Rundel did not stop to consult with any civilians who were present.

As he approached the handrailing near the swinging glass doors, Cst. Rundel saw Mr. Dziekanski standing on the secure side of the doors, behind a chair. He did not see any broken glass. He described what he saw:

> I was able to observe that he was very unkempt, in my opinion, hair was matted. He gave the appearance of perhaps he had been sweating. He had a – what I would term as a wide-eyed glazed focused look, but perhaps disoriented. With – with the information received on the dispatch ticket of him possibly being intoxicated, to me he did have that appearance that it was a possibility. He seemed to be, from what I recall, moving, not standing still.

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[74] At the time of the Dziekanski incident, Cst. Rundel had 18 months' experience, after completing his training at Depot and his six months' recruit field training. When he testified, he was 48 years old.

> He – I believe he moves away from the chair and seems to be – however I best can describe it is I guess in an agitated state of some sort. Just beyond what I would call somebody who was behaving normally.[75]

b. Entering the secure area

Cst. Rundel told me that when he entered the secure International Reception Lounge area, two of the other officers were already approaching Mr. Dziekanski and attempting to communicate with him, so he decided not to. Based on the information he had received from dispatch, he was anticipating that they would be dealing with an individual who was arrestable. He did not know whether Mr. Dziekanski was coming or going, and he did not know if the three suitcases he saw were Mr. Dziekanski's. However, his training and experience taught him that he needed to further analyze the situation, so he was gathering information at that point. He estimated that Mr. Dziekanski was about 5'10" or 5'11" tall, and weighed about 190 pounds.

Cst. Rundel heard Cst. Bentley address Mr. Dziekanski in a friendly, low, calm tone of voice, something to the effect of "Hi, how are you doing, how's it going?" He did not recall Mr. Dziekanski responding, although he remembered Mr. Dziekanski speaking in a foreign language at about this time. There were three pieces of luggage to the right of the swinging glass doors, near the console desk.

Although Cst. Rundel did not testify about hearing Cst. Millington ask Mr. Dziekanski for his passport, he did tell me that Mr. Dziekanski turned and bent or kneeled, and pointed toward his luggage. Cpl. Robinson said, "No" in an authoritative, stern voice, and put out the palm of one or both hands, giving him a command by body language, conveying the message, "You're not going into your luggage." Cst. Rundel concluded that Mr. Dziekanski understood this command, because he stopped and stood up. He added:

> [H]e did a very quick – quick flick of his hands and arms in a motion that to me said, "To hell with you guys, I'm out of here," and then he went off to his left to where the counter was located.... And he had his – the front of his – his body was to the counter. He, at that point, and I didn't see this myself, he had

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75 Transcript, February 23, 2009, p. 18.

> grabbed a metal object that was later determined to be a stapler with his right hand, and swept along the counter, quickly turned to his left with his back to the counter.
>
> I recall seeing the stapler in his hand, in his right hand come across his upper shoulder/face area, where he immediately had a firm grasp of it, and brought his elbow down towards his chest with his fist grasping the stapler up in his upper chest area. At the same time his left – left arm came up into a fist, a firm fist with his elbow locked, and also brought it up to his upper chest area. His – I believe his left foot came forward at that time. And again this is all happening split-second, happening very fast.
>
> It was at during – during that time that Mr. Dziekanski had moved away and positioned himself with the stapler.[76]

Cst. Rundel positioned himself directly in front of Mr. Dziekanski, about six to eight feet away. Cst. Bentley was to his left and behind, Cpl. Robinson was to his right, and Cst. Millington was farther right. He told me that when Cpl. Robinson said, "No" to Mr. Dziekanski (meaning not to go into his luggage) and Mr. Dziekanski stood up, flipped up his hands (as if to say, "To hell with you guys"), and turned away, that was a non-compliant action and his behaviour was resistant. Cst. Rundel said that when Mr. Dziekanski picked up the stapler and held it as he did, he displayed combative behaviour, although one cannot see his arms or hands on the Pritchard video (3:46).[77] Cst. Rundel told me that it was his observation that Mr. Dziekanski had full intention of using the stapler as a weapon to assist in his possible use of force on the officers. At this point, he feared for his safety to a certain degree. From his training he knew that officers are authorized to deploy a conducted energy weapon in the face of this type of resistant behaviour, although he added that every situation is different and a conducted energy weapon is not deployed against everyone who is resistant.

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[76] Transcript, February 23, 2009, p. 28.

[77] References to the Pritchard video refer to a video recording on the incident (in three segments) taken by a civilian witness, Paul Pritchard, who was waiting in the public Meeting Area. When referring to events recorded on the Pritchard video, I will refer to the minutes and seconds recorded on that video. According to the synchronization material prepared by counsel for the Vancouver Airport Authority, the first segment of the Pritchard video began at 1:21:22 a.m. YVR time on October 14, 2007, the second segment began at 1:25:10, and the third segment began at 1:32:10. The four officers arrived on scene during the second segment of the Pritchard video.

Cst. Rundel told me that they positioned themselves tactically in a semicircle around Mr. Dziekanski:

> It's all to do with safety issue. For training purposes, we're taught in training, this individual went quickly from uncooperative to resistant to combative, including picking up a stapler, which can elevate the level of aggression, indicating to me that this individual was a risk to the public, to myself, and to himself, and my other officers. There's a safety issue.[78]

Cst. Rundel never considered that Mr. Dziekanski might be frightened. Now that he has seen the video showing Mr. Dziekanski's behaviours before the officers arrived, and other information that has been received, he agreed that it is possible that he was frightened. However, at the time, this was a high-risk situation based on the information they had, and no single officer was going to go in there and try to calm him down.

Cst. Rundel did not recall the stapler ever being above Mr. Dziekanski's head, or Mr. Dziekanski motioning with it toward Cst. Rundel or shooting staples out of the stapler. He recalled Mr. Dziekanski stepping forward with his left foot, but otherwise did not recall seeing his body move forward.

Cst. Rundel was referred to the notes that he made in his notebook that morning, while still at the Airport, in which he wrote:

> 0130 hours in secure side held stapler – yelling arms up – not English – stepped towards us in front of counter. Cst. Millington deployed tazer.

He told me that the notes he made were limited, because he knew that he would be interviewed later. He said that his notes meant that Mr. Dziekanski was holding the stapler, with his arms up toward his upper chest, in a combative posture. He could not be sure whether the yelling was before or after the weapon was deployed. His reference to stepping toward the officer refers to his testimony about Mr. Dziekanski taking a step forward with his left foot.

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[78] Transcript, February 24, 2009, p. 37.

Cst. Rundel was also referred to the statement he gave Sgt. Attew of the Integrated Homicide Investigation Team (IHIT) at 5:00 a.m. that morning, in which he stated:

> He picked up a stapler, and he started ... clenching his fists and ... and, putting the stapler up above his head, mo-motioning ...making motions with it, uh ... towards us. Um ... and then at that point, Constable MILLINGTON had ... pulled out his ... TASER, and ... activated it.

He told me that the statement may have some of the events out of chronological order, but that was how he remembered it at the time he gave the statement. When asked whether the stapler was above Mr. Dziekanski's head prior to the weapon being deployed, he told me that it was likely that the stapler was in his hand when his hand swept across his face, although he did not actually see the stapler at that moment. As to whether Mr. Dziekanski made motions with the stapler toward him, Cst. Rundel told me:

> When he's making a swinging motion across his face with a stapler, given the fact that everything is happening in a very split-second timeframe, my perception of that time is a swinging motion that could be perceived as also coming out in front of his face as opposed to – as opposed to close to his face and then coming across to his chest.[79]

Cst. Rundel was also referred to the October 18, 2007, statement he gave to Cpl. Brassington, in which he stated:

> ... he ... then picked up a ... stapler ... turned around, he had both fists in the air with the stapler [INDECIPHERABLE] his hand, and was motioning ... motioning towards us in an ... aggressive combative style, and ... that's ... when Constable MILLINGTON ... um ... activated the TASER.

Cst. Rundel told me the statement was accurate, and supported his earlier statement. He was not able to see, on the Pritchard video, the swinging motion Mr. Dziekanski made after picking up the stapler, when he brought the stapler around to the front of his body at the shoulder/head level. He thought it might have occurred when the video picture is obscured by a reflection on the glass wall (3:42–3:45). He clarified:

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[79] Transcript, February 23, 2009, p. 49.

"The stapler above the head, making motions towards us would be after the second TASER deployment."[80]

Cst. Rundel was asked why four officers, standing a safe distance away from Mr. Dziekanski, did not have time to give him a warning before the conducted energy weapon was deployed. He said:

> As I said yesterday, I feared for my safety, and at that point when I fear for my safety ... but due to the fact that it was happening so fast and that Mr. Dziekanski went from the resistant to the combative with an object, stapler, in his hand, we acted and responded appropriately in that situation.[81]

According to his training, a conducted energy weapon causes less harm than a baton or pepper spray, and is an option when a subject displays this behaviour. He was trained that deploying a conducted energy weapon a second time should not cause any additional harm.

Cst. Rundel disagreed that Mr. Dziekanski had taken a defensive position, stating:

> ... there's no doubt in my mind that he took up the combative stance and he had every intent to injure, attempt to injure, harm us officers, and anybody else in the public that was in the area that he would have access to was also a possibility, no doubt in my mind.[82]

Cst. Rundel was asked whether he, in the company of three other officers, was really concerned that Mr. Dziekanski was capable of running away. He answered:

> We all keep ourselves physically fit. And as I said yesterday, it took a TASER, two deployments, four officers for over a minute struggle, to restrain and handcuff Mr. Dziekanski, which is an incredible amount of energy on Mr. Dziekanski's part.
>
> If we, in fact, had not put a semicircle around him and not contained him and he'd fled and got into any of those other public areas where other people were, with that amount of energy that he had built up inside, I venture to say I don't know where that could have ended, but it could have gone bad. It could have – he could have injured, hurt other members of the public. He was not in a frame of mind that he was thinking rationally.

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[80] Transcript, February 23, 2009, p. 58.

[81] Transcript, February 24, 2009, p. 41.

[82] Transcript, February 25, 2009, p. 16.

> So the amount of energy that I experienced that he had, if he were to use that in any other way than resisting us on members of the public, that was a dangerous situation for the public.[83]

c. *Deployment of the conducted energy weapon*

Within split seconds, Cst. Millington deployed the weapon. Although Cst. Rundel did not recall hearing a warning that the weapon was going to be deployed, he thought there must have been one, because he remembered knowing that it was going to be deployed. He heard the bang when the weapon was deployed. Although he did not see the probes lodge, Mr. Dziekanski responded in a way consistent with the probes having lodged and with receiving an electrical current. He was yelling and screaming. He remained standing in a combative posture, with his fists clenched and the stapler in his hand. This surprised Cst. Rundel, because he learned during training that a subject would fall to the ground. His observation was that Mr. Dziekanski appeared to be almost fighting through it. He heard Cpl. Robinson instruct Cst. Millington, while Mr. Dziekanski was still standing, to deploy the weapon a second time, by saying, "Hit him again." After the second deployment Mr. Dziekanski released the stapler, and fell to the ground at some point after that. Then, Cst. Rundel, Cst. Bentley, and Cpl. Robinson moved in to subdue and restrain Mr. Dziekanski, feeling it was safe to do so.

Cst. Rundel was asked about his October 14, 2007, statement, in which he stated that two other officers and he "made contact with, with the male and ... wrestled him to the ground." He acknowledged that this was not accurate: "He was down on the ground and then we came in and handcuffed."[84]

Cst. Rundel said that he was trained to move in and restrain a subject while the electrical current was still flowing through, if he considered it otherwise safe to move in – the current should have no effect on the officer. Having been subjected to a five-second conducted energy weapon deployment himself during training (which he described as a very painful experience), it was his understanding that a subject returns to full strength immediately after the current stops.

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[83] Transcript, February 25, 2009, pp. 11-12.

[84] Transcript, February 23, 2009, p. 52.

He agreed that in his October 14, 2007, statement he suggested that Mr. Dziekanski might have been experiencing excited delirium, given his superhuman strength, and that in such circumstances a conducted energy weapon is the appropriate response. He told me:

> That's correct. It's a – with somebody that's, in the training, with excited delirium the objective is to subdue them as quickly as possible with the least amount of force, and the TASER is, in training, is an option for a less level of force, even as opposed to baton and pepper spray....
>
> That was somebody that is suffering from excited delirium, that there's all these physiological characteristics that are going on within their body, and they're basically, for lack of a better word, they're on this downhill spiral towards expiring....
>
> And the – option is, according to the training, is to try to get this person, you know, as quickly as possible, with the lowest level of force as possible, in order to give this person a better chance of surviving.[85]

d. Restraining Mr. Dziekanski

Cst. Rundel told me that Mr. Dziekanski was lying on his chest, kicking his legs, with both arms locked beneath his body. Cst. Rundel placed his right knee on the floor against Mr. Dziekanski's upper right chest area to prevent him from moving that way. He placed his left knee onto Mr. Dziekanski's upper right leg, to stop the kicking motion, and then put his upper chest area toward Mr. Dziekanski's upper back area. Cst. Rundel, with Cpl. Robinson's assistance, tried to get Mr. Dziekanski's right arm freed from underneath his body so that they could handcuff it. Cst. Rundel could not recall whether there was any conversation among the officers – he was intent on getting Mr. Dziekanski into handcuffs. He was not aware that the conducted energy weapon was deployed more than twice. He believed that Mr. Dziekanski was still being resistant during the struggle; it did not cross his mind that any of his movements and noises might have been in response to the weapon discharge.

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[85] Transcript, February 24, 2009, pp. 54-55.

At the same time, Cst. Bentley was trying to unlock Mr. Dziekanski's left arm, and in the process lost his handcuffs. Cst. Rundel and Cpl. Robinson were able to get Mr. Dziekanski's right arm behind him, and Cst. Rundel applied his handcuffs. The three officers were then able to unlock Mr. Dziekanski's left arm and handcuff it as well. The entire struggle lasted about one minute.

After the handcuffs were in place, there was a kicking motion in Mr. Dziekanski's legs for five to fifteen seconds, after which he stopped resisting. From Cst. Rundel's experience, this was quite normal. Mr. Dziekanski was lying on his chest or stomach, breathing heavily. He placed his hand on Mr. Dziekanski's back for support, in case he tried to resume struggling. At that point, Cpl. Robinson instructed Cst. Rundel to go out to his vehicle and retrieve hobbles – straps attached to the ankles that are then secured back up to the handcuffs, with the legs bent backwards.

e. Attending to Mr. Dziekanski

When he returned a minute later, Cpl. Robinson was kneeling down with Mr. Dziekanski. Cpl. Robinson told Cst. Rundel that the hobbles were not needed. Mr. Dziekanski was rolled onto his right side, and Cst. Rundel assisted with a pat-down and quick search of Mr. Dziekanski. He retrieved a wallet from Mr. Dziekanski's coat pocket. He did not determine whether Mr. Dziekanski was conscious, and at no time did he observe Mr. Dziekanski's skin turn blue.

Cst. Rundel did not observe any of the other officers check Mr. Dziekanski's pulse. However, Cpl. Robinson was kneeling down next to Mr. Dziekanski, and Cst. Rundel assumed that Cpl. Robinson was able to monitor his breathing. About two minutes before the firefighters arrived, Cst. Rundel knelt down near Mr. Dziekanski, who was lying on the right side of his chest, with his right leg straight and his left leg slightly bent. He heard him breathing and snoring.

f. Arrival of the Richmond firefighters

While Cst. Rundel was in the public Meeting Area talking to Mr. Pritchard, he saw the firefighters arrive. He went back inside to see if any assistance was needed.

Cpl. Robinson was kneeling beside Mr. Dziekanski. The female firefighter knelt down and began her assessment of Mr. Dziekanski. The male firefighter made a request to Cpl. Robinson to remove the handcuffs. Cpl. Robinson said no, because he was concerned that Mr. Dziekanski might regain consciousness and become violent. The firefighter accepted that answer.

g. Arrival of the BC Ambulance Service paramedics

Cst. Rundel said that when the paramedics arrived (about a minute after the firefighters), a second request was made to remove the handcuffs. Cpl. Robinson instructed Cst. Rundel to move in and remove the handcuffs, which he did.

h. Post-incident discussions with the other officers

Cst. Rundel told me that after the incident he had generalized discussions with the other officers about the trauma they were going through, but other than that he has been very careful not to discuss details of the incident and what his evidence would be at this Inquiry.

i. Post-incident reconsiderations of the officers' actions

Cst. Rundel said that after viewing the Pritchard video, he saw that the video fully supported his version of the events and the details that he gave in his statements.

Cst. Rundel told me that Mr. Dziekanski's death, which was never intended, was a very terrible outcome. Since the incident, much has been learned about what happened. He added:

> A I'm sure there isn't one person that's looking back and wondering, you know, if they could have done something differently.... But given the fact that we came in without all that prior knowledge and had to deal with the situation with the limited information we had, I can't – I can't say that I could have done anything differently. I'm – that's unfortunate, but that is how it is.

Q	You regret what happened, of course?
A	Of course.[86]

2. Constable Bentley[87]

a. Responding to the call for assistance

Cst. Bentley told me that the RCMP's Airport sub-detachment had two conducted energy weapons. They were stored in a lockup safe, available to officers on a first-come, first-served basis. His normal practice was to check the safe when he came on duty. He wore one while on duty at the Airport sub-detachment about once every three shifts. He likely checked the safe when he came on duty on October 13, 2007, but there must have been no weapons available.

He heard the dispatch call over his radio while he and the other three officers were in the lunchroom of the Airport sub-detachment. There was no discussion of the call, or who would attend.

En route to the Airport, he did not activate his siren or lights. He received a dispatch update, but got no other information over the radio, and had no discussions with the other officers. He stated:

Q	Was there a plan in place as to how to deal with Mr. Dziekanski once you got to this point?
A	There was no plan in place. I think, based on the information we received, we wanted to attend the call as soon as we could and make an assessment as to what was going on before we decided any appropriate action.
Q	Now, why wouldn't there be a plan in a case like this, on a call like this?
A	A call like this, it's – quite frankly, it's hard to plan for. You really need to go and assess before you develop any sort of plan.

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[86] Transcript, February 24, 2009, p. 75.

[87] Cst. Bentley received a B.A. degree in Criminology from the University of Windsor in 2004, after which he worked as a Canada Border Services Agency officer, and completed a basic first aid course. He graduated from RCMP Depot training in May 2006 and was assigned to the City of Richmond detachment. He completed the RCMP conducted energy weapon training in July 2007, and was assigned to the Airport sub-detachment in early September 2007.

Q	And what sort of assessment had you anticipated conducting?
A	The main assessment I wanted to do was to speak with the subject of complaint, analyze the area, speak with him, see what his mental state was at.[88]

He had no conversations with the other officers at the doors leading into the International Terminal building. As he was entering the building, a female employee of Horizon Airways approached him. She was very excited and in a very high fast voice told him, "He's over by the glass." Cst. Bentley said that this Horizon employee also told him that Mr. Dziekanski was breaking the glass or trying to break the glass. He did not receive or hear any other information from other civilians.

Cst. Bentley told me that the other three officers did not say anything to him. He described what he saw and did as he approached the handrailing:

> Based on the information that we had received about the call, as we were walking towards the male he was standing there just staring at us with his eyes wide open, hands at his side, and debris was around his feet. From my law enforcement experience, my gut instinct told me that he was going to start a fight with us. I did what I simply call is a tool check, and I wanted to see if we had a CEW available to us as an intervention option if he became combative. I wasn't sure at the time if any of the other officers had a CEW on their person. I was a little bit ahead of the group at the time, so I kind of turned my head back to the side and directed a general question at the other officers, asking them something to effect of, "Do you have a TASER on [i.e., on their person]?"[89]

This initial assessment, that Mr. Dziekanski was going to start a fight with them, was based on the dispatch information (that he was breaking and damaging furniture, was extremely intoxicated, and was throwing chairs through glass), what the Horizon employee told him, the debris around Mr. Dziekanski's feet, and the way he was standing staring at the officers. "To me, this is not the behaviour of a rational person. I thought that perhaps he was emotionally disturbed and unpredictable." He did not see any broken glass, which he agreed was an indication that some of the initial information he had received was exaggerated. He added that when they initially engaged Mr. Dziekanski, he was cooperative. Cst. Bentley did not expect that Mr. Dziekanski may start a fight, but he just wanted to be prepared for it.

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[88] Transcript, February 25, 2009, pp. 111-112.

[89] Transcript, February 25, 2009, p. 61.

Before entering the secure area, Cst. Bentley did not stop and question any civilians, did not hear anyone saying that Mr. Dziekanski did not speak English, and did not receive any directions or instructions from the other officers. In his view, Cst. Millington was the lead investigator, Cpl. Robinson was the supervisor, and Cst. Rundel and he were assist officers, and that did not change throughout the incident. Based on what he had been told and the debris he saw at Mr. Dziekanski's feet, he thought they had reasonable and probable grounds to arrest him for mischief. Mr. Dziekanski was initially calm, and if that continued, Cst. Bentley expected that they could arrest him with little or no force.

Cst. Bentley agreed that in his October 14, 2007, statement to the IHIT investigator, he said that as they approached the glass partition separating the public Meeting Area from the secure International Reception Lounge, he could see Mr. Dziekanski on the secure side: "[T]he male was uh, just kinda looking at us. From his demeanour he looked like he was uh, waiting to fight."[90]

b. Entering the secure area

As the swinging glass doors opened and the officers entered the secure area, Cst. Bentley said to Mr. Dziekanski, "Hi, how are you, sir? How's it going, bud?" He did not get a verbal response. Mr. Dziekanski's demeanour seemed calm. His hands were at his side, and he was cooperative. He was fairly close to Mr. Dziekanski and did not smell any liquor on his breath. All four officers were close together. Cst. Millington took over as lead investigator and started to engage Mr. Dziekanski. He said something to him, and a few seconds later Mr. Dziekanski turned around, threw up his arms and walked away from them toward a desk. As Mr. Dziekanski did so, Cpl. Robinson took over, saying something to Mr. Dziekanski and using hand gestures, swinging his arms out. Cst. Bentley continued:

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[90] Transcript, February 26, 2009, p. 16.

> I remember Mr. Dziekanski looking side-to-side on the desk, turning his head left to right. I got the feeling then that he was looking for some sort of object to use against us. I remember seeing a stapler on top of the desk. I remember him grabbing that with his right hand and turning around with it, swinging it out in front of him. At that particular time myself and Corporal Robinson were the closest members to Dziekanski. We were very close, actually, to the point that I thought I was going to be hit with the stapler. I tactically repositioned back, and while I was doing that I grabbed my defensive baton and deployed it. I remember once my defensive baton was deployed, I looked at the peripheral of my right eye and I saw that Constable Millington had deployed the TASER and I heard a – like a loud sound, the sound of the CEW being deployed and striking Mr. Dziekanski.

Cst. Bentley told me that when Mr. Dziekanski put his arms up and moved away, he thought Mr. Dziekanski was trying to evade them and might be trying to flee: "He's being defiant, that he doesn't want to listen to us, that he's had enough of dealing with us."[91] He described this behaviour as non-cooperative, although he agreed that his assessment might have been different if he had known that Mr. Dziekanski was moving in the same direction that one of the other officers (Robinson) was pointing. Mr. Dziekanski was about an arm's length away from Cpl. Robinson and him.

Cst. Bentley was referred to the Pritchard video (3:39-3:45), which shows Cpl. Robinson with his arm out horizontally, pointing toward the counter, and Mr. Dziekanski moving in that direction. He told me that he noticed this pointing action when he first viewed the video. When asked how he interpreted Cpl. Robinson's pointing, he stated:

> I interpret that observation as Mr. Dziekanski had turned around, thrown up his arms, began to walk away from us and because he's being defiant, Corporal Robinson is now ordering him to the desk or to put his hands on the desk.[92]

He was asked whether, if Cpl. Robinson did in fact order Mr. Dziekanski to move over to the counter, Mr. Dziekanski's body language of shrugging and raising his arms into the air could be interpreted as an act of resignation and compliance. He answered:

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[91] Transcript, February 25, 2009, p. 70.

[92] Transcript, February 26, 2009, p. 71.

"Perhaps.... I just think it's open for interpretation. It could be read that way. I can't give a definitive yes."[93] He could not offer another possible interpretation.

When Mr. Dziekanski swung the stapler around (3:46) and Cst. Bentley thought he was going to hit him with it, Cst. Bentley began to tactically reposition himself to his left. Mr. Dziekanski was now about two feet greater than arm's length away, and the stapler came within a foot or two of himself. The stapler was in the closed position, it was not pointed at him, and Cst. Bentley did not recall any staples being discharged. At that point, Cst. Bentley began to draw his baton with his left hand, "In my mind, he's now armed himself with a weapon, has the intent on using it against us, and I need to react accordingly."[94] In his view, Mr. Dziekanski was now displaying combative behaviour, which justified use of an impact weapon such as a baton. He said that when Mr. Dziekanski swung around with the stapler, he had a concern for the personal safety of himself, the other officers, and members of the public who might enter the area.

Cst. Bentley said that he did not hear Mr. Dziekanski scream until the weapon was deployed against him. He was referred to a note he made in his notebook before leaving the Airport that stated, "Subject grabbed stapler and came at members screaming." He told me that when he made the note he believed it was accurate, but then added:

> Everything happened so fast. I was tired when I made my notes. After getting adequate amount of sleep, adequate time to reflect on the incident, as well as watching the video to refresh my memory, I realized that it was incorrect.[95]

When he was asked whether looking at the video made him realize that Mr. Dziekanski had not come at them screaming, he stated:

> A Just to clarify, I believe that it's somewhat accurate, it's just out of sequence. And when I wrote those notes, I had got confused with after – pardon me, when he was TASERed

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[93] Transcript, February 26, 2009, p. 83.

[94] Transcript, February 25, 2009, p. 115.

[95] Transcript, February 25, 2009 p. 76.

> for the first time, when he was TASERed, he was screaming and his body movement from the TASER caused him to kind of move forward. And I think that's why there was some confusion and I had put that in my notes.
>
> Q Okay.
> A I think it was just out of sequence.[96]

Cst. Bentley said that although he included in his notes that Mr. Dziekanski came at them screaming, he did not say anything to that effect in his three written statements to IHIT investigators.

Cst. Bentley was asked to reconcile his testimony, to the effect that Mr. Dziekanski did not point the stapler at him, with his statement to the IHIT investigator at about 5 a.m.: "He grabbed a stapler and, uh, started to kinda aiming it at members." He stated:

> A There was just – sorry, there was just some confusion with him swinging the stapler out and whether he was pointing it, or I do believe he was in fact pointing it at the members. He had finished swinging it out and it was held out in front of him, and I took that as a gesture as he was pointing that at us.
>
> Q Okay. So do you want to modify the answer you gave earlier today?
> A Yes.
>
> Q Okay. Tell the Commissioner how you'd like to change the answer you gave earlier today, now that you've seen your statement.
> A I'd like to change my answer to state that he had swung the stapler out in front of him and it was pointing at myself.[97]

In his October 14 statement, Cst. Bentley stated that when the four officers gained entrance to the secure side they kept their distance from Mr. Dziekanski, who was staring at them. At that point Mr. Dziekanski started looking around – it was like he was looking for a weapon. When it was suggested to Cst. Bentley that Mr. Dziekanski did not look around for a weapon when the officers entered the secure area, he responded:

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[96] Transcript, February 25, 2009, p. 76.

[97] Transcript, February 25, 2009, p. 78.

> What I was actually describing in my statement was – referring to was when he walked over to the desk and he was turning his head side-to-side. I just hadn't articulated that to the corporal, but that's what I intended to mean.[98]

Cst. Bentley was asked why he went directly into the secure International Reception Lounge, jumping over the handrail, rather than approaching more casually and getting more information from bystanders. He responded:

> A Well, there was no urgency at the time, but I felt that we were dealing with someone who was acting irrationally, so you wanted to be near him or at least engage him as soon as possible.
>
> Q Well, did you think that jumping over the barricade might just make him feel a little more nervous?
> A That's not something that crossed my mind at the time.[99]

Cst. Bentley agreed that in his October 14 statement he said that Mr. Dziekanski started backing up, looking for something to grab, grabbed the stapler, and swung it out at them. Mr. Dziekanski adopted a triangle stance with his feet spread apart and his arms down at his side. He told me:

> A I just interpreted that his feet were wider apart than perhaps normal for balance and that at any time his arms could come up and perhaps engage us.
>
> Q Yeah. Because your mindset from the minute you left the detachment, "I'm in for a fight," right?
> A It was in the back of my mind to be prepared for a fight.[100]

Cst. Bentley was asked about rushing Mr. Dziekanski:

> Q Did you ever rush at Mr. Dziekanski in an effort to physically control him?
> A No.

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[98] Transcript, February 26, 2009, p. 17.
[99] Transcript, February 26, 2009, p. 22.
[100] Transcript, February 26, 2009, p. 24.

Q Why not?
A Because I feared for my safety.

Q Why did you fear for your safety, sir?
A Because he's armed himself with a weapon. And if I try to engage him with just my hands, there's a good chance that I could get hurt.[101]

c. *Deployment of the conducted energy weapon*

Cst. Bentley told me that he believed at the time that the conducted energy weapon was deployed twice, both times in probe mode. He was not aware, until the report from Crown Counsel was released, that it had been deployed more than twice. His recollection was that Mr. Dziekanski was still standing when Cpl. Robinson gave Cst. Millington the instruction to "hit him again," although Mr. Dziekanski may have collapsed to the floor before the weapon was actually deployed the second time, as the video suggests.

He maintained his view that Mr. Dziekanski appeared to be fighting through the weapon's discharge: "I don't know whether he had any voluntary control over his body, but it was the expression on his face as well as the screaming and the way he did it that made me believe he was trying to fight through it."[102]

He told me that in his training he was taught to use the level of force that the subject is displaying, or a force higher than that of the subject.

d. *Restraining Mr. Dziekanski*

Cst. Bentley said that Mr. Dziekanski fell to the ground as a result of the first deployment of the conducted energy weapon. He agreed that his statement to the IHIT investigator, that Cpl. Robinson and Cst. Rundel took him down, was inaccurate. After Mr. Dziekanski fell to the floor, those two officers moved in to restrain him. When Cst. Bentley saw that Mr. Dziekanski was putting up a very big struggle, he moved in to assist them. He attempted to get Mr. Dziekanski's left arm behind his back so that he could be handcuffed. He pulled out his handcuffs but was not successful in handcuffing him – every time he got close, Mr. Dziekanski would grab his handcuffs in what Cst. Bentley perceived to be an effort to avoid being put into restraints. Cst. Rundel was able to handcuff Mr. Dziekanski with his handcuffs, so Cst. Bentley put his away. He could not recall receiving any information or directions from other officers, before the handcuffs were applied.

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[101] Transcript, February 26, 2009, p. 63.
[102] Transcript, February 26, 2009, p. 87.

Cst. Bentley said that he had no recollection of Cst. Millington deploying the conducted energy weapon in push-stun mode after the two probe-mode deployments – he was focusing on his task of trying to get Mr. Dziekanski into restraints.

Cst. Bentley told me that he has been involved in more than 100 arrests but has never seen a situation where it took four officers to restrain someone.

He was aware that Mr. Dziekanski was making noises before he was handcuffed, but he interpreted those noises and his movement as resistance to being handcuffed, not a response to the weapon. He explained that a response to the weapon would last only as long as the weapon was discharging – it would only be a few seconds followed by breaks. In this case, Mr. Dziekanski's struggling was continuous until he was handcuffed.

He told me that he pulled out his defensive baton before the conducted energy weapon was deployed, but he did not use it against Mr. Dziekanski. When he was unable to slide it between his tool belt and pants, he laid the baton on the floor. He is shown on the video banging the tip of the baton on the floor, which he said he did in order to collapse it. He said that he did this after Mr. Dziekanski was handcuffed; he was three or four feet away from Mr. Dziekanski, or a little bit closer. He could not say whether Mr. Dziekanski reacted to this.

e. Attending to Mr. Dziekanski

Cst. Bentley told me that Mr. Dziekanski moved a little bit for five to ten seconds after being handcuffed, then stopped. Mr. Dziekanski was lying on his side like in the recovery position, handcuffed behind his back with his eyes closed. Cst. Bentley was facing Mr. Dziekanski, Cpl. Robinson was behind him, and Cst. Rundel was near his feet. Cst. Bentley observed that Mr. Dziekanski went unconscious, although he could see his chest moving up and down, and he could hear him breathing quite loudly: "It's a loud breathing like when you go out for a hard run, you exhaust yourself physically, trying to catch your breath."[103] Although he knew how to perform a proper breath test and carotid pulse test, he did neither, nor did he see any of the other officers check his pulse or breathing.[104] However, he observed an Airport Operations man in a black suit check Mr. Dziekanski's carotid pulse.

When he realized that Mr. Dziekanski was unconscious, he immediately called for Emergency Health Services to attend. His call was for a routine response – he would only have requested Code 3 if the subject was unconscious and not breathing. He added:

A	Shortly after I made my initial call, his skin started turning a bluish colour. I became deeply concerned, so I upgraded the call to Code 3.
Q	And how did you do that?
A	Using my portable radio and requesting dispatch to contact EHS and have them arrive Code 3.[105]

He told me that it was Mr. Dziekanski's face that turned a light bluish colour. The colour persisted, but never got darker. He had no discussions with other officers or civilians about Mr. Dziekanski's condition before upgrading the call to Code 3. He told me that when Mr. Dziekanski initially went unconscious, he thought it might be an act, but when he saw Mr. Dziekanski's face turn blue five or ten seconds later, he knew it was not. He agreed that, given Mr. Dziekanski's unconsciousness, laboured breathing, and turning blue, they were facing a medical emergency, and he was very concerned, which is why he requested Code 3. He realized that Mr. Dziekanski might require cardiopulmonary resuscitation. However, he took no steps to have a defibrillator brought to the scene, thinking that Cpl. Robinson or the Airport Operations employee who had taken Mr. Dziekanski's pulse would take the initiative.

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[103] Transcript, February 25, 2009, p. 95.

[104] Cst. Bentley said that in his notes he stated that he saw Cpl. Robinson monitor or check Mr. Dziekanski's pulse. He agreed that the note was incorrect.

[105] Transcript, February 25, 2009, p. 94.

Cst. Bentley told me that about four minutes after the weapon was first deployed, Cpl. Robinson (who had been continuously kneeling behind and bending over Mr. Dziekanski) instructed him to go out to his cruiser and retrieve a camera and audio recorder, which he did. On his return, he took photographs inside the secure area (Exhibit 46) and, at Cpl. Robinson's direction, interviewed several witnesses in the public Meeting Area.

f. Arrival of the Richmond firefighters

Cst. Bentley said that he was in the public Meeting Area when the Richmond firefighters arrived, not in the International Reception Lounge as shown on the diagram marked by Captain Graeme (Exhibit 17).

g. Post-incident discussions with the other officers

Some time after 2:30 a.m., Cpl. Robinson instructed Cst. Bentley to return to the Airport sub-detachment and to wait for Integrated Homicide Investigation Team officers to attend, and to provide them with a statement. Cst. Rundel returned at about the same time. Cpl. Robinson remained at the scene, but Cst. Bentley had no recollection of seeing Cst. Millington back at the sub-detachment.

Cst. Bentley was asked whether he discussed the events at the Airport with the other officers:

> Q But are you telling us, today, that you have no memory of you and your fellow officers at the sub-detachment before IHIT arrived and before the staff representative arrived, of discussing the events that had just transpired and each officer's version of those events?
>
> A Yes, that's what I'm saying, I don't remember.
>
> Q Now, you're saying you don't remember the details of a conversation or you don't remember whether there was even any discussion among the officers about the events that had transpired?

> A I'm saying I don't remember if there was any discussion with fellow offers [*sic*] – officers about the events that transpired....
>
> Q Is it your testimony that since leaving YVR's terminal and heading back to the sub-detachment, you have no memory of ever discussing with Corporal Robinson the events in question and comparing your version against his version?
>
> A What I do remember is we did have what's referred to as a critical incident debrief, where we all told our version of the events that transpired that evening....
>
> A Everyone gave their version of the events. There was no discussion amongst members, they just told their side of the story. That was it.[106]

Cst. Bentley told me that when the IHIT investigator interviewed him, he knew that his response was going to be why he had used force that night or that he was going to have to justify using force that night.

h. Post-incident reconsiderations of the officers' actions

Cst. Bentley told me that after he viewed the Pritchard video on television, his memory was refreshed and he remembered that he had made a comment to the other officers as to whether they were carrying a conducted energy weapon. He contacted the IHIT investigators in order to set the record straight, and was interviewed again on November 22, 2007.

Cst. Bentley was asked whether there was anything that he would like to say to Mr. Dziekanski's mother. He responded:

> That I'm sorry for her loss and that my heart goes out to her and her family.[107]

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[106] Transcript, February 26, 2009, pp. 79-81.

[107] Transcript, February 25, 2009, p. 123.

3. Constable Millington[108]

a. Responding to the call for assistance

Cst. Millington told me that he obtained a conducted energy weapon when he came on duty on the evening of October 13, 2007, and spark-tested it. They were available on a first-come, first-served basis.

He and the other three officers were having lunch together when the dispatch call came in. He was the first to respond, so the call was assigned to him. There was no discussion of the call when it came in to the lunchroom, and there was no instruction or assignment about who was to attend. All four officers got up, left and went to their separate cars, and proceeded to the International Terminal building without lights or sirens. En route to the Airport, Cst. Millington received the dispatch information on his computer. The only part of the message he paid attention to was the location. The message read: "Intox 55yr male in international arrivals in reception lobby throwing luggage around // non-white, drk hair white coat as per ops // no other details avail." While driving to the scene, he received an update stating, "Male is now throwing chairs thru glass windows in that area."

Cst. Millington was asked about communications among the four officers:

> Q Was there any discussion amongst the four officers en route to the Airport building?
> A No....
>
> Q And when you got out of your cars and before you actually physically entered the Airport, did you and your other three officers have any discussion about the call?
> A No....
>
> Q And no discussion amongst the four officers about the call in any way up to the point of your entry into the Airport?
> A No.[109]

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[108] Cst. Millington received a Bachelor of Commerce degree from Ryerson University in 2000. He completed his RCMP Depot training in May 2005, and his six-month field training at the City of Richmond detachment in November 2005. He continued at that detachment until July 2006, when he was transferred to the Airport sub-detachment. He completed the conducted energy weapon training program in July 2007, taught by Cpl. Gillis. He had completed basic first aid training before joining the RCMP.

As they entered the International Terminal building, Cst. Millington heard some yelling, but did not understand it and did not know where it was coming from. He heard a civilian say, "He doesn't understand English. He speaks Russian." He did not remember receiving any other information. Cst. Bentley turned to him and asked whether he had a TASER, and Cst. Millington said, "Yes." There was no other discussion between him and his fellow officers, or with civilians, prior to entering the secure area.

As Cst. Millington approached the swinging glass doors, he saw Mr. Dziekanski on the secure side, walking back and forth, pacing. He was not breaking anything or making threatening gestures, and Cst. Millington saw no signs of broken glass or any indication that luggage had been thrown around. He did observe that there were some chairs near Mr. Dziekanski that were somewhat blocking the doorway. That observation, plus the yelling he had heard, satisfied him that there was some accuracy to the initial dispatch information.

Cst. Millington said that Mr. Dziekanski was agitated. He was sweating and breathing heavily, and his eyes were really wide. He suspected that Mr. Dziekanski was under the influence of a drug or alcohol, but he did not smell any alcohol.

b. Entering the secure area

Cst. Millington described what happened after he entered the secure area:

> When I got into the secure area, like I said, he was walking back and forth. He was very – seemed very sweaty and his eyes were wide, and seemed very agitated. What I tried to do then is to use some hand signals, because I heard that he didn't understand English, to try to get him to calm down. I pushed my hands towards the floor and I mentioned what I thought to be universal words, I used two words, "passport" and "identification." He didn't seem to understand. So I put my hand up and motioned with a mime pen, I guess you could say, to try to further, I guess, explain myself.
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> At that point he threw his hands up and I interpreted that to be defiant. He turned away from us and knocked some things off the desk that was behind him. I don't know what he knocked off. He then picked up a stapler, which

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109 Transcript, March 2, 2009, pp. 11-12.

> was on that same desk and he turned towards us and it was in the open position. He held it up with one hand, fist with the other, and started to approach us with hands up, and I deployed the TASER at that point.[110]

He told me that when he watched the Pritchard video he realized that Cst. Bentley had greeted Mr. Dziekanski by saying something like "hello, sir," although he did not recall hearing it at the time. The hand gesture he made in order to get Mr. Dziekanski to calm down involved placing his hands at chest height, with palms facing down to the floor, and pushing his hands down. This gesture, which he made as soon as he saw Mr. Dziekanski, is not captured on the Pritchard video. He said that the hand gesture he made after saying, "passport" and "identification" can be seen on the Pritchard video, at 3:38.

Cst. Millington said that he did not see Mr. Dziekanski go toward his luggage, but did see him go toward the desk. At the time, he did not see Cpl. Robinson point toward the desk because he was focused on Mr. Dziekanski, but did see it later on the Pritchard video. When asked whether he thought Mr. Dziekanski's movement toward the desk was an act of compliance with Cpl. Robinson's direction, he stated:

> He was moving towards the table. Corporal Robinson was also pointing towards the table, but I interpreted that from looking at the video that he was doing it regardless of where Monty, Corporal Robinson was pointing.[111]

Later in his testimony, Cst. Millington agreed that if Cpl. Robinson told Mr. Dziekanski not to go near his bag and he stepped away from it, that would be obeying an instruction. However, he later said:

> Q So Officer, my question here is in the context of you now appreciating that it becomes apparent that Corporal Robinson is ordering or commanding Mr. Dziekanski to go to the counter. Would you now agree that the body posture of Mr. Dziekanski raising his hands, shrugging his shoulders and turning around and heading away towards the counter is, in fact, and can only be interpreted as an act of total compliance?

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[110] Transcript, March 2, 2009, pp. 18-19.

[111] Transcript, March 2, 2009, p. 22.

A	As I've said before, I still see it as a movement of defiance based on the way he moved his hands.[112]

Cst. Millington was referred to his October 14 statement, which included the following:

> We went in and ... saw some chairs lying around and a male who was yelling and it wasn't making sense. Someone yelled that he didn't speak English, so we tried to calm him down by using hand signals ... you know, try to calm down, and he backed away from us and he was still yelling. He didn't listen to anything we were saying.[113]

He agreed that the chairs were not lying around, but were standing. He agreed that his reference to Mr. Dziekanski yelling may have been wrong. He told me that when Mr. Dziekanski turned away from the officers, he interpreted that as not listening to them.

Cst. Millington was asked about "excited delirium":

Q	Now, during your training, were you told anything about a condition referred to as agitated or excited delirium?
A	Yes. We were told that sometimes a person can exhibit excited delirium – symptoms of excited delirium, and we're trained that the TASER is a very effective tool because if someone is exhibiting excited delirium or has that condition, they are normally focused and aggressive and other methods of intervention do not have an effect, and the TASER is most effective for that, because it causes immobilization and we can gain control of a subject that's exhibiting those – that condition, if you will....
Q	On the night in question, did you – did it occur to you that Mr. Dziekanski might be exhibiting some of the signs of agitated delirium as you'd been trained?
A	Yes. Basically, what I saw with regards to him being sweaty and his eyes really wide, and I think I said clammy in my notes as well, to that agitated state is very typical of someone who is – who has excited delirium or is under that – has that condition, sorry.

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[112] Transcript, March 3, 2009 pp. 111-112.

[113] Transcript, March 2, 2009, p. 32.

> Q All right. Did making those observations have any impact on what you decided to do at the scene?
>
> A When I got there, no. I wanted to communicate with him, and that was my primary goal.[114]

Cst. Millington added that he was trained that people with excited delirium must be restrained before they can be treated; there can be no medical treatment without restraint, so restraint is the first goal.

He was referred to various portions of the training materials he used during his conducted energy weapon training that dealt with the medical safety of the weapon, which included statements to the following effect:[115]

- Modern pacemakers and implanted cardiac defibrillators withstand external electrical defibrillators at least 800 times stronger than the weapon's conducted energy pulses;
- Animal testing has shown insignificant effects on heart rhythms or blood pressure;
- In more than 100,000 human volunteers, 99 percent were incapacitated;
- The weapon was applied directly to the chest of experimental animals without causing heart failure during testing at the University of Missouri; and
- Using "worst-case" scenarios, cardiac safety experts found no induction by the model M26 weapon of abnormal heart rhythms.

Cst. Millington told me that he had no recollection of Mr. Dziekanski saying something in Polish moments before he deployed the weapon.

c. *Deployment of the conducted energy weapon*

Cst. Millington demonstrated how Mr. Dziekanski was holding the stapler in the open position at chest level. He was asked for his rationale for deploying the conducted energy weapon:

> He had the stapler open, his other fist raised. He's – was in a combative stance, as we call it, and was approaching the officers, I believe, with the intent to attack. So I deployed the TASER at that point.[116]

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[114] Transcript, March 3, 2009, pp. 74-75.

[115] See Exhibit 61, pp. 1-4.

He agreed that Mr. Dziekanski was not approaching him, and Cst. Bentley had gotten out of the way, so Mr. Dziekanski was moving toward either Cst. Rundel or Cpl. Robinson. He deployed the weapon in probe mode on his own initiative, without any instruction from another officer to do so. He did not dispute the data download analysis conducted by Cst. Baltzer, showing that the first weapon discharge lasted six seconds, which means that Cst. Millington held the trigger down for that period of time. He agreed that the sounds Mr. Dziekanski made were very loud and were consistent with extreme pain. He told me that he believed that Mr. Dziekanski was still standing at the completion of the first discharge so, one second later, he discharged it again in probe mode for five seconds. He gave his rationale for doing so:

> From my training, the effects of the TASER being fired are that the person that it's applied against is supposed to fall immediately, and that's supposed to immobilize him. It did not have that effect on Mr. Dziekanski, so I felt it was necessary to fire it again, and so I did.[117]

He said that he discharged the weapon the second time on his own initiative without any instruction from another officer. At the completion of that discharge, Mr. Dziekanski was on the ground. At that point the other officers moved in to restrain Mr. Dziekanski and get his arms behind his back, but he was kicking and fighting and struggling with them. Cpl. Robinson instructed him to deploy the weapon again, which he did in probe mode. However, the weapon made a clacking sound when he deployed it that, according to his training, meant that the current was not going through properly. Since Mr. Dziekanski's kicking and struggling was consistent with his behaviours before the third deployment, Cst. Millington concluded that no electrical current was flowing at all.

Consequently, Cst. Millington removed the cartridge from the weapon and deployed it in push-stun mode against Mr. Dziekanski's rear shoulder area in an attempt to get pain compliance so the other officers could get his arms behind his back. He did so on his own initiative and without telling anyone that he was going to do so. He did not

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[116] Transcript, March 2, 2009, p. 23.
[117] Transcript, March 2, 2009, p. 25.

dispute that the data download recorded a nine-second discharge. He could not say exactly how long the weapon was in contact with Mr. Dziekanski, but he was sure that it was less than the nine seconds, because Mr. Dziekanski was moving and struggling, and he heard the same clacking sound, which in push-stun mode, means the weapon is not in contact with the subject.

Cst. Millington told me that he recalled deploying the weapon only four times. He was advised that Cst. Baltzer's data download analysis showed a fifth deployment in push-stun mode for six seconds. He told me that when he viewed the video he could hear the clacking sound for this entire period, which indicated to him that, "I may have been holding the trigger, but it definitely was not in contact with him."[118]

He told me that he had never deployed a conducted energy weapon in the field before this incident. He was trained that the conducted energy weapon is the least injurious method (to the subject) to gain control of a subject. In this case, he did not see where the two probes landed and did not know whether both probes made contact. He was also trained that, to achieve safety, an officer's level of intervention should always be one step higher than the force being used. He said that he was trained that multiple discharges of the weapon may be dangerous, and that they should be avoided whenever possible unless situational factors dictate otherwise.

Cst. Millington said that he listened with headphones to the Pritchard video and to an enhanced audio version, and prepared a table identifying when he heard clacking during the second through fifth deployments of the weapon (see Exhibit 53):

Deploy	Video clacking	Audio clacking
2	03:57 - 03:59	03:58
3	04:15 - 04:17	04:15 - 04:18
4	04:28 - 04:31	04:24 - 04:26 04:29 - 04:31
5	04:35 - 04:36 04:38 - 04:40	04:35 - 04:40

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118 Transcript, March 2, 2009, p. 27.

Cst. Millington told me that if he had known at the time that Mr. Dziekanski had fallen to the floor during the first discharge of the weapon, he would not have deployed it again right away: "I would have reassessed the situation and we would have tried to move in and take control, similar to what we did before the third application, and if it was necessary, I would have applied the TASER at that time."[119] He told me that, from viewing the Pritchard video, he had moved around to the other side of Mr. Dziekanski before the time of the fifth deployment of the weapon: "I may have, due to the stress of the situation, been holding the trigger, but it definitely was not in contact with Mr. Dziekanski at the time."[120]

He also agreed that a reference in his October 15 statement (to the effect that he cycled the weapon twice because Mr. Dziekanski was still standing) was in error – he was on the ground by the end of the first cycle, although at the time he believed Mr. Dziekanski was still standing. However, he maintained the accuracy of his statements to IHIT investigators that after Mr. Dziekanski picked up the stapler he "approached" or "moved towards" or took one or two steps toward the officers – he told me that it is shown on the Pritchard video at 3:49. He was also referred to a portion of his October 15 statement in which he said, "He reached and grabbed the stapler, had it in the open position and had it raised high and then started advancing toward us." He said that by "high" he meant Mr. Dziekanski had it above his waist. He maintained this position later in his testimony:

> Q I put it to you, sir, the impression you were trying to convey was that he had this thing up in the air, correct?
> A That's not the impression that I got from it. "High" can mean over the waist or high above the shoulder....
>
> Q Well, there's a significant difference between raised high and raised to waist level, right?
> A Raised above waist level?

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[119] Transcript, March 3, 2009, pp. 4-5.
[120] Transcript, March 3, 2009, p. 5.

Q Yeah.
A High can be above waist level, yes.

Q Are you seriously asking us to believe, sir, that you weren't intending to convey to the corporal that this thing was raised up in the air?
A I didn't intend that, no.[121]

Later in his testimony, he was asked what he would expect a subject to do, if he ordered the subject to "put your hands up high":

A Either raise them here (gesturing) or raise them high above their head.

Q If you instructed a person to raise their hands high, wouldn't you expect them to raise them in the manner I'm raising them?
A It could be that or it could be just above the waist.[122]

Cst. Millington was asked why he deployed the weapon the third time:

A Well, just after this the other three members move in and I soon follow to attempt to gain control of the male. He was combative, but we're still – didn't have him under control. So when they were – attempts to gain control of him, he was still kicking and fighting with the members and was not moving his hands behind his back, and that's when I was advised to use it again.

Q Advised by Corporal Robinson?
A Yes.

Q So was the decision to fire the third shot yours, or were you following the instruction of your corporal?
A I heard his instruction, but it was my decision.[123]

Cst. Millington agreed that, because of the medical risks associated with multiple deployments, he was trained to avoid repeated deployments unless situational factors dictate otherwise. However, he acknowledged that when he made his reassessment before each deployment after the first one, he did not weigh the issue of medical impairment that might arise – it was a fast-moving situation and he was acting according to his training.

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[121] Transcript, March 3, 2009, p. 47.

[122] Transcript, March 3, 2009, p. 119.

[123] Transcript, March 2, 2009, pp. 42-43.

d. Restraining Mr. Dziekanski

Cst. Millington was referred to several passages in his handwritten notes and his October 14 and 15 statements, in which he stated that the officers wrestled Mr. Dziekanski to the ground. He agreed that all those passages were in error, "That's what my notes said and my statement, and he fell to the ground on his own. I made those notes and statement at the time, but he had fallen on his own. I didn't realize that."[124]

e. Attending to Mr. Dziekanski

Cst. Millington told me that a minute or two after Mr. Dziekanski was handcuffed, Cst. Bentley said to him that Mr. Dziekanski's ears were turning blue, and Cst. Bentley called Code 3. Cst. Millington agreed that this was a serious medical development and he was concerned. He would have called Code 3 if Cst. Bentley had not. He suggested that Mr. Dziekanski be moved into the recovery position, to allow for better breathing and circulation. He had done this for other subjects in handcuffs.

Cst. Millington was aware that Mr. Dziekanski was not moving, but did not know whether he was unconscious. He did not check his pulse or breathing or check for airway obstruction, and did not observe Cst. Rundel or Bentley do so. He asked Cpl. Robinson if Mr. Dziekanski was breathing, and he said, "Yes." Cst. Millington was referred to his handwritten notes (Exhibit 57), which included the following entry:

> Member/writer observed Cpl. ROBINSON check pulse every couple of mins while male was in recovery position. Male had a pulse.

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[124] Transcript, March 2, 2009, p. 36.

Prior to the arrival of the Richmond firefighters, Cst. Millington did not see Mr. Dziekanski move and did not observe anyone else check Mr. Dziekanski for pulse, breathing, or airway obstruction.

Cst. Millington was referred to a section of the Operational Manual that states: "Ensure the individual receives medical attention if any unusual reactions occur or if you think that he or she is in distress." He said that he thought he discharged his responsibilities under that provision – there was no obstructed airway or laboured breathing, and Mr. Dziekanski had a pulse. He did not think that it was necessary to ask an Airport security person to obtain a defibrillator. Although he was aware that Mr. Dziekanski's ears had turned blue, he added, "I didn't look forward to what that might have led to."[125] He expected that the ambulance would arrive quickly after it had been upgraded to Code 3.

He was also referred to the "excited delirium" section of the Operational Manual that states: "If no EMS is present at the scene and the subject suddenly becomes quiet and stops resisting, EMS should be summoned and preparation be made for CPR." He told me that he believed that Mr. Dziekanski had been prepared for CPR, by turning him into the recovery position; the handcuffs could be removed quickly when the medical first responders arrived.

f. Arrival of the Richmond firefighters

Cst. Millington told me that when the Richmond firefighters arrived, Cpl. Robinson was near Mr. Dziekanski's upper body area and he was further back by the leg area. He thought that Cst. Rundel and Cst. Bentley were in front, but he was not sure. Cst. Millington stood back to give the firefighters more room. He heard them ask that the handcuffs be removed, and thought Cpl. Robinson complied, but did not hear any conversation.

Cst. Millington agreed that the conducted energy weapon training materials advised the officer to tell those giving medical attention that the subject had been subjected to 50,000 volts of electricity, and to make available to medical personnel the Medical TASER Information Sheet. He told me that he had no recollection of this information sheet, and it did not occur to him to tell the Richmond firefighters about the number of times he had deployed the weapon against Mr. Dziekanski: "I was not part of the conversation and other members were aware that multiple times were used."[126]

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[125] Transcript, March 4, 2009, p. 26.

g. Accuracy of his notes and statements

Cst. Millington made handwritten notes while still at the Airport and gave written statements to IHIT investigators on October 14, 15, and 18.[127] He was referred to the notes he made while still at the Airport. He agreed that some of the statements in his notes were inaccurate, including that the weapon was cycled three times and that members wrestled him to the ground. "It was my best recollection at the time. It was a fast-moving, stressful situation, and that is what I jotted down at the time."[128] However, later in his examination it was pointed out that his notes also referred to deploying the weapon in push-stun mode to the upper back and shoulder area, for a total of four deployments.

He was asked whether he panicked his notes and statements were wrong because he did not have a good recollection of events. He answered, "Actually, I do, and like you said, I made some mistakes in the statement, but my overall recollection I think was good."[129]

h. Post-incident discussions with the other officers

Cst. Millington said that he and Constables Rundel and Bentley were told to return to the Airport sub-detachment to await arrival of the IHIT investigators, which they did. He was asked about any discussions they had:

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[126] Transcript, March 2, 2009, p. 57.

[127] Cst. Millington told me that the RCMP's staff relations representative told him that he was entitled to seek legal counsel before giving a statement to the IHIT investigators. He felt that he had acted within his training, and chose not to seek legal advice before giving any of the statements.

[128] Transcript, March 3, 2009, p. 32.

[129] Transcript, March 3, 2009, p. 64.

Q	Did the three of you discuss at all what you had seen and heard relating to Mr. Dziekanski prior to the time you sat and gave your statement?
A	No.[130]

He agreed that in late October 2007 the four officers participated in a critical incident debriefing session. He disagreed with the suggestion that each of the officers explained to each other what they had done in the incident. "No. We discussed with the psychologist with regards to how we were feeling with regards to the end result."[131]

He told me that about five weeks after the Dziekanski incident he was transferred out of the Airport sub-detachment. During those five weeks he worked some shifts with the three other officers, but he never discussed the incident with any of them and never overheard them discussing it, even after the Pritchard video became public. Since his transfer he has had no discussions with any of them about the incident.

It was suggested to Cst. Millington that:

- He and his fellow officers collaborated to fabricate their story in the expectation that it would justify their conduct to their superiors;
- He was fast at work at the scene of the incident cooking up his story and that he continued his collaboration back at the detachment office; and
- He and his fellow officers intentionally misled the IHIT investigators and that he continued to lie under oath at this Commission.

Cst. Millington denied all these allegations.

i. Completion of the conducted energy weapon usage report

Cst. Millington told me that he completed the RCMP's Conducted Energy Weapon Usage Report (Form 3996) on about October 18 or 19, 2007. The summary portion of the report included the following:

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[130] Transcript, March 2, 2009, p. 63.

[131] Transcript, March 2, 2009, p. 64.

> Initial Dispatch Information: Complaint of a male throwing luggage around and throwing chairs through windows. At time of arrival, members approached the male who was yelling and standing on the secure side of the arrivals area. The male had destroyed a computer and had damaged Airport property on the secure side. The male did not speak English and was moving around erratically and would not listen to members who used hand signals to attempt to get the male to calm down. When members got closer to the male, he stepped back and away. The male then deliberately knocked items off of a desk nearby and grabbed an office stapler. The male swung the stapler wildly with his arm at the members. Cst. MILLINGTON unholstered the CEW and pointed it at the male subject. The male was not apprehensive upon seeing the CEW. The male raised the stapler in one hand and raised the other fist. The male then aggressively moved towards members on scene. Cst. MILLINGTON recognized the male's behaviour had escalated from resistant to combative, and deployed the CEW. The CEW was deployed once for the full 5 seconds, which stopped the male from moving, but he continued to walk towards members with his arms raised once the cycle was completed. Cst. MILLINGTON cycled the CEW a second time, after which members were able to wrestle the male to the floor. The male was still struggling at this time and Cst. MILLINGTON cycled the CEW again. However, the CEW electrical impulse was audible, which meant that at least one of the probes were not attached. Cst. MILLINGTON took the cartridge off of the CEW and used the push-stun mode on the man's rear deltoid (upper back) area. At this point, members were able to control the male and get him into handcuffs. Cst. MILLINGTON then reloaded the CEW with a new cartridge and re-holstered the CEW.[132]

Cst. Millington agreed that several of the statements contained in the summary were inaccurate, including the following:

- Mr. Dziekanski was not yelling;
- Mr. Dziekanski was not swinging the stapler wildly with his arm at the members;
- The first cycle of the weapon was six seconds, not five seconds;
- After the first weapon deployment, Mr. Dziekanski did not continue to walk toward the officers with his arms raised; and
- The other officers did not wrestle Mr. Dziekanski to the floor after the second cycle – he fell to the floor himself after the first cycle.

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[132] See Exhibit 54, p. 3.

When it was suggested that the summary might give a distorted view of what happened, Cst. Millington replied, "There are errors in it, yes."[133] He agreed that those errors would cause someone to get an impression that might be different than what one might see on the Pritchard video. Cst. Millington maintained that when Mr. Dziekanski picked up the stapler, had his fists raised and the stapler up, and advanced toward them, this was combative behaviour. He feared for the safety of the other officers and himself because he thought Mr. Dziekanski was going to attack. He deployed the weapon to stop the threat.

j. Post-incident reconsiderations of the officers' actions

Cst. Millington was asked whether, in hindsight, he would have done anything differently:

> Q Now, you've now had the benefit of hindsight and the benefit of the video. Would you have done anything differently?
> A No. We acted in accordance to our training. Of course I never intended this result.
>
> Q When you say you never intended this result, what are you referring to?
> A I never intended for Mr. Dziekanski to pass away.[134]

4. Corporal Robinson[135]

a. Responding to the call for assistance

Cpl. Robinson had just stepped out of the lunchroom when the dispatch call came in, but he heard it on his portable radio. Cst. Millington responded to it, but Cpl. Robinson had no discussion with the three constables about who should attend. He told me, "When the call comes in, Constable Millington responded, so another member is going to go with him. Then a third member went and I went up as well just to oversee and to supervise."[136] They responded as though it were a Priority 2 call, meaning that it was a "hurry up and get there" call because it was an "in progress" call.

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[133] Transcript, March 2, 2009, p. 74.

[134] Transcript, March 2, 2009, p. 100.

[135] Cpl. Robinson was, at the time of his testimony, 38 years old. He grew up in the Lower Mainland and obtained a Bachelor of Arts degree from Trinity Western University in 1994. He graduated from RCMP Depot training in July 1996, and served for seven years in the Chase, BC, detachment. In 2003 he was transferred to the Merritt detachment and, while there, was promoted to Corporal. At his request he was transferred to the City of Richmond detachment in August 2005, and then to the Airport sub-detachment in April 2007, where he served until November 2007.

He told me that there was no discussion en route to, or on arrival at, the Airport about the call, or in response to the update that the subject was now throwing chairs through glass. He had no plan in his mind about what he would do with this call as he entered the Airport. When he was asked about the types of dispatches that would normally call for an operational plan, he said:

> If you're looking at plans, certain police responses demand a plan, whether it be a hostage taking, armed robberies, things that are happening in progress. Those are the types of calls that you'd actually have a plan for. And this call this evening was not one of them.[137]

Each officer drove his own vehicle, and Cpl. Robinson was the fourth officer to arrive. He was asked why he, as the most senior officer, did not take charge of the investigation. "I only step in if necessary. A lot of how the members are going to gain that experience is by dealing – interacting with people, and I only step in if I have to."[138]

As he was moving through the public Meeting Area toward the swinging glass doors, Cpl. Robinson heard someone say words to the effect of "he only speaks Russian," and he heard an Airport security person say words to the effect of "he's freaking out." He did not have any discussion with people in the area. He was intent on getting into the secure area to assess the situation, to observe the constables in their interactions, and to step in if necessary. Having heard that there might be broken glass, he stopped and put on his gloves. Around the time he jumped over the handrailing and approached the glass doors, he heard Cst. Bentley say to Mr. Dziekanski, "How's it going, bud? How you doing, sir?" He denied the suggestion that the officers "entered like a SWAT team" or that it was a "cowboy entrance." They had to hop over the railing, or otherwise walk all the way around the railing.

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[136] Transcript, March 23, 2009, p. 10.
[137] Transcript, March 23, 2009, p. 81.
[138] Transcript, March 23, 2009, p. 78.

b. Entering the secure area

Cpl. Robinson said that as he entered the secure area his attention was focused on Mr. Dziekanski and the other three officers. He was not aware of anyone else being in the immediate vicinity. He saw a damaged computer terminal on the ground, but did not see any broken glass. Mr. Dziekanski was standing inside the glass doors with the other members – he was not throwing or breaking anything.

Although he could not hear any conversation about a passport or identification, Cpl. Robinson saw Mr. Dziekanski turn and reach down toward the luggage. He considered that to be a potentially dangerous situation to the other officers, because it was unknown what was in the luggage. In this type of situation, the best thing to do is have the individual step back and have the officers look at what the individual was going for. Consequently, Cpl. Robinson stepped in and took charge. He put his hand out and said, "No. Stop." He told me that Mr. Dziekanski stopped going toward his luggage and was thus complying with his direction. He made a motion for Mr. Dziekanski to calm down, and then pointed with his finger and motioned with his hands for Mr. Dziekanski to put his hands on the counter. He told Mr. Dziekanski to calm down and to put his hands on the counter, although he realized that Mr. Dziekanski would not understand. Mr. Dziekanski threw up his hands and took a step back. Cpl. Robinson started moving around to reposition himself, to get Mr. Dziekanski to put his hands on the counter.

Cpl. Robinson agreed that at one point in the video it is possible to see the stapler on the counter. He insisted that he pointed at the counter, but did not point in the general direction of the stapler.

c. Deployment of the conducted energy weapon

Mr. Dziekanski had transitioned around quickly and raised his voice louder. Cpl. Robinson saw that Mr. Dziekanski was clenching a stapler in his fist, and his other fist was down. Mr. Dziekanski made motions with his fist, and a couple of staples discharged. Cpl. Robinson said that this was combative behaviour, which under the RCMP's Incident Management/Intervention Model (IM/IM), justified use of a baton. He continued:

> And I had taken a step back and he walked, or he took a step forward with the clenched fist, and he took a step forward and at that point I had drawn my defensive baton. I pulled it out but I did not extend it. And so I had my defensive baton.
>
> Constable Millington was off to my right. The other members had transitioned off to my left, and in what order, I don't know. So when he did that, or when he grabbed the stapler, the members pulled off this way around me and Constable Millington was to my right. I had my defensive baton out and when he took the step forward, that's when I gave Constable Millington the command to deploy the TASER. And at that point the TASER was deployed.[139]

Cpl. Robinson identified a point on the Pritchard video (3:45) where he stepped back, but acknowledged that it was a "very slight movement."[140] It would not have been appropriate to step back farther (e.g., 10 feet) because they had Mr. Dziekanski contained, and given the escalation of his level of violence, the officers had a duty to keep him contained in order to protect themselves and the public. A viewing of the video (3:47) shows that Cpl. Robinson pulled out his baton (but did not snap it in order to extend it) and held it up at head level. Cpl. Robinson decided that it was preferable to have Cst. Millington deploy the conducted energy weapon rather than use his own baton, because the conducted energy weapon can give instantaneous control and creates less risk of injury to the subject. In his view, Mr. Dziekanski did not afford them an opportunity to say, "Put it down" or to give the TASER warning before deploying the weapon, given his combative nature, grabbing the stapler, and taking a step forward.

Cpl. Robinson told me that he said to Cst. Millington words to the effect of "Kwesi, hit him with it," but it was deployed before he had time to say, "TASER, TASER."

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[139] Transcript, March 23, 2009, p. 24.

[140] Transcript, March 23, 2009, p. 32.

Cpl. Robinson told me that the first deployment did not have the instantaneous effect it should have had, based on his previous experience. Mr. Dziekanski had not gone down and was still holding the stapler. He gave the command to deploy the weapon again (before Mr. Dziekanski fell to the ground), but he does not know if Cst. Millington heard him or if the weapon was deployed a second time. Mr. Dziekanski moved to Cpl. Robinson's left and then fell to the ground in a tripping motion, at which point Cpl. Robinson moved in behind him to try to control him.

Cpl. Robinson was referred to 4:13 of the Pritchard video, where "Hit him again, hit him again" is heard. He would not rule out that those were his words but, if they were, it must have been a third command, because he made the first two commands before Mr. Dziekanski fell to the floor (at 3:55). If he did give a third command, it was justified because Mr. Dziekanski was able at certain points to push himself back up. He explained, "At that point, if we're losing control of him, the use of the conducted energy weapon is appropriate."[141] Cpl. Robinson told me that he did not consider that Mr. Dziekanski's attempts to push himself back up might have been an attempt to breathe or in response to the pain from the weapon.

Cpl. Robinson said that he was aware from his conducted energy weapon training that there were risks associated with deploying the weapon continuously without a break for 15 to 20 seconds.

d. Restraining Mr. Dziekanski

Cpl. Robinson said that when the officers attempted to put handcuffs on, Mr. Dziekanski resisted by pulling away, pulling his arms in and kicking. It required concerted effort by both him and Cst. Rundel to get one of Mr. Dziekanski's arms in position to be able to put the handcuffs on. When asked to compare Mr. Dziekanski's resistance to other subjects he has handcuffed, he stated, "I would rank him as one of the hardest people I've ever had to arrest or put the handcuffs on, as far as strength goes at that time.... His ability to resist was very extreme."[142]

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[141] Transcript, March 23, 2009, p. 41.

Cpl. Robinson was asked whether, in attempting to restrain Mr. Dziekanski, he placed his knee on the back of Mr. Dziekanski's neck. He denied doing that. He placed his knee across Mr. Dziekanski's shoulder blades, in accordance with his training. Doing so is safer than placing a knee on the neck, and it is also more effective, in that it prevents subjects from rolling over or picking themselves up. He estimated that he has used this technique more than 50 times while on duty. He has never seen a subject expire, suffer serious injury, or go unconscious from using this technique.

Cpl. Robinson was shown a 24-second segment of the Pritchard video (5:10-5:34), which shows him kneeling near Mr. Dziekanski's head, with his left leg on the floor near Mr. Dziekanski's back, and his right leg and/or knee on or near Mr. Dziekanski's neck. When asked whether this did not show that his right leg and/or knee were on Mr. Dziekanski's neck, he repeatedly asserted, "I know where my knee was and it was nowhere near his neck," and "I didn't apply pressure to the back of the neck."[143]

He told me that after Mr. Dziekanski was handcuffed, he instructed Cst. Rundel to go out to his vehicle and retrieve hobbles. He did this because of Mr. Dziekanski's kicking and struggling. Even after he had been cuffed, it did not seem that Mr. Dziekanski was slowing down.

e. *Attending to Mr. Dziekanski*

Cpl. Robinson said that after Mr. Dziekanski went unconscious, he rotated him into a modified recovery position. He could not be placed into a total recovery position while handcuffed.

Cpl. Robinson told me that he was aware that Mr. Dziekanski's ear (not his face) turned blue. He knew, from his first aid training, that this could be a medical issue of breathing or bruising. Since Mr. Dziekanski was breathing, he assumed it was caused by bruising. By then, Code 3 had already been called. Later in his testimony he said, "I didn't know if it was bruising or breathing, but we called the ambulance."[144] Cpl. Robinson was referred to his October 14, 2007, statement to an IHIT investigator in which he said, "... because it was almost like, during the struggle, it's almost like he was getting a blue discolouration."[145] He agreed that this was inaccurate – he saw that the ear was blue after he rolled him into the partial recovery position, but did not see it turning blue during the struggle.

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[142] Transcript, March 24, 2009, p. 94.

[143] Transcript, March 25, 2009, pp. 62-63.

He told me that after Mr. Dziekanski was handcuffed, he constantly monitored his breathing until the Richmond firefighters arrived. He did this by placing his hand on Mr. Dziekanski's chest, observing his mouth for breathing, and by placing his head close to Mr. Dziekanski's head so he could hear his breathing. Initially he heard what he thought was snoring, which alerted him to the fact that Mr. Dziekanski was unconscious. He also checked Mr. Dziekanski's pulse a couple of times, after Mr. Enchelmeier had checked it. He told me that he removed his gloves each time before checking the carotid pulse and that his bare hand can be seen on the Pritchard video (third segment) at 0:06.

f. Arrival of the Richmond firefighters

Cpl. Robinson told me that he had Mr. Dziekanski in a modified recovery position and was kneeling behind Mr. Dziekanski's back when the Richmond firefighters arrived. He had no recollection of refusing the firefighters' request that the handcuffs be removed, although he might have done so. He acknowledged that he was reluctant to remove the handcuffs, given the nature of the call (that Mr. Dziekanski was combative, had damaged property, and was potentially violent against the officers). In his experience, he had seen subjects regain consciousness and come up swinging, almost in fight mode.

Cpl. Robinson was referred to the testimony of Richmond Fire Captain Graeme, to the effect that after he and Firefighter Cameron did an assessment of Mr. Dziekanski before the arrival of the ambulance paramedics, his view was that Mr. Dziekanski was dead. Cpl. Robinson told me that he had no recollection of Captain Graeme telling him that – he first learned of Mr. Dziekanski's death after the paramedics had dealt with him.

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[144] Transcript, March 23, 2009, p. 47.
[145] Transcript, March 24, 2009, p. 35.

g. *Arrival of the BC Ambulance Service paramedics*

Cpl. Robinson said that when the ambulance paramedics asked for the handcuffs to be removed, he asked whether they could work on Mr. Dziekanski with the handcuffs on, and they said they would like them off. He agreed to remove them. He told me, "I believed he still posed a risk and for me to take them off – and I had told them that they have to be ready to step out of the way if he comes up swinging."[146]

h. *Accuracy of Cpl. Robinson's notes and statements*

Cpl. Robinson was referred to his October 14, 2007, statement to an IHIT investigator, in which he stated in part: "I remember him taking a step forward and then he was swinging the stapler ... up high and then he's just like he's swinging it um, to try to push us back or ah, an attempt to hit us."[147] With respect to the statement, "an attempt to hit us," he agreed that he did not articulate it that well that morning. With respect to his reference "up high," he was intending to refer to shoulder or chest height.

He was referred to passages in his statements where he told IHIT investigators that the officers had to wrestle Mr. Dziekanski to the ground. He told me:

> I was mistaken but I was telling the truth. At certain points we did wrestle with him, but like I have on page 3, he did – he did drop to the ground. So the TASER did take him down, and I sort of blended the whole interaction with him and I was mistaken. But at the time I did the best job I could in articulating it.[148]

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[146] Transcript, March 23, 2009, p. 51.

[147] Transcript, March 23, 2009, p. 58.

[148] Transcript, March 23, 2009, p. 68.

It emerged later in Cpl. Robinson's testimony that on March 2, 2009, his lawyer wrote to the Commission, stating in part, "The officers did not take Mr. Dziekanski to the ground. Rather, they struggled with Mr. Dziekanski after he was on the ground. The struggle was to gain control and to ensure that Mr. Dziekanski remained on the ground."[149]

He was referred to passages where he described Mr. Dziekanski as swinging the stapler. He agreed that he had been inaccurate:

> A He swung but then he brandished it, and it wasn't swinging initially. But I sort of blended the whole interaction and I was just trying to clarify it. But just because I was mistaken doesn't mean I was lying. I did the best job I could at the time.
>
> Q So if you said in your statement that he was swinging the stapler, are you saying that's inaccurate?
> A Yes.
>
> Q Do you realize that in your statement you used the word "swinging" twelve times?
> A Yes.[150]

Later in his testimony, it emerged that Cpl. Robinson's counsel's March 2, 2009, letter to the Commission stated in part: "Rather than use the word 'swing' or 'swinging', Corporal Robinson feels that the word 'brandish' or 'brandishing' better captures the majority of Mr. Dziekanski's actions with respect to the stapler."[151]

Cpl. Robinson was referred to his October 14, 2007, statement in which he said:

> ... like he started snoring, so um, I said, I put him out, 'cause I was the one positioned on the top of him? At that point I pulled off and ah, we, we positioned him almost in like the recovery position?[152]

He was asked whether his statement, "I put him out" indicated that he thought that he was responsible for Mr. Dziekanski losing consciousness? He disagreed, adding, "I was trying to draw the attention to the members that he's no longer pushing up and he's snoring, so the fact that he went out."[153] Cpl. Robinson was referred to another similar passage in his statement in which he used the expression, "I put him out," and he again denied that he meant that he had rendered Mr. Dziekanski unconscious.

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[149] Transcript, March 24, 2009, p. 104.
[150] Transcript, March 23, 2009, p. 69.
[151] Transcript, March 24, 2009, p. 57.
[152] Transcript, March 24, 2009, p. 61.

i. Post-incident discussions with the other officers

Cpl. Robinson told me that during the two-hour period after Mr. Dziekanski died and before the IHIT investigators arrived at the Airport (approximately 4 a.m.), he had no discussions with the other officers about the incident, other than directing them to get the names of witnesses so that they could be interviewed later.

He said that after IHIT investigators arrived at the scene, he instructed the three constables to return to the Airport sub-detachment to be interviewed. When asked whether he gave them any instructions, he said, "I would have given them the standard things of just don't talk about it. Wait till after you give your statements to IHIT."[154]

He told me that although he worked at the Airport sub-detachment with the other three officers for five weeks after the incident, he had no discussions with them about the incident (other than during the critical incident debriefing session) and has had no discussions with them about the incident since then. He had no recollection of discussing, at the critical incident debriefing session, any material facts relating to the incident.

j. Post-incident reconsiderations of the officers' actions

Cpl. Robinson was asked how he now felt about the events as they unfolded that night:

> A The events — like this is a tragic thing that happened and it saddens me any time I have to look at them. This has been the hardest last couple of months to go through this. And you know, this should not have happened. No one should have passed away. And its not — it's not where — every day

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[153] Transcript, March 24, 2009, p. 61.

[154] Transcript, March 23, 2009, p. 56.

> doesn't go by where I think about this and replay this through my head. And then having to sit here and go through the video, yes, it's one of those things that's really hard to keep together. But it's just been a very difficult time. But this never should have happened.
>
> Q With that comment in mind – this should have never happened – is there anything that you did, from your perspective, that contributed to this event that you can see?
>
> A No.[155]

Cpl. Robinson was asked what he meant when he said, "[T]his never should have happened." He responded that he did everything consistent with his training and they called an ambulance, but Mr. Dziekanski should not have died. He added that there was no reason for Mr. Dziekanski to pick up the stapler, and the autopsy report was inconclusive as to the cause of death. The officers all responded based on Mr. Dziekanski's behaviour, and there was nothing that they could have done differently.

It was suggested to Cpl. Robinson that he and his fellow officers:

- collaborated to fabricate their story in the expectation that it would justify their conduct;
- were fast at work at the scene cooking up the story and that they continued their collaboration at the detachment office; and
- intentionally misled the IHIT investigators and that he continued to lie under oath before this Commission.

Cpl. Robinson denied all these allegations.

5. Staff Sergeant Douglas Wright

Staff Sergeant **Douglas Wright** was the officer-in-charge of the Vancouver International Airport sub-detachment of the Richmond RCMP detachment. He testified that at about 2 a.m. on Sunday, October 14, 2007, he received a phone call at home from Cpl. Robinson, who was still at the Airport. Cpl. Robinson advised him that there had been an incident at the Airport in which a conducted energy weapon had been deployed, that the subject was in serious medical distress, and that BC Ambulance Service paramedics were attending to him. There appeared to be a serious issue as to whether the subject was going to survive. Cpl. Robinson used the term "excited delirium" in relation to why the weapon was deployed.

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[155] Transcript, March 23, 2009, p. 90.

Cpl. Robinson told him that they had received information before their arrival that the subject had been throwing chairs and computer screens around. He described the subject as being agitated, uncooperative, and non-compliant.

Staff Sgt. Wright told me that he had a second phone conversation with Cpl. Robinson at 2:11 a.m. Cpl. Robinson asked for advice about what to do with a civilian witness who had videotaped the event. Staff Sgt. Wright told him to hold the witness and the tape and, when the Integrated Homicide Investigation Team arrived, turn them over to IHIT. He added:

> A ... I also provided him direction to tell the members – because I recognized at that time that they were going to be part of this investigation as witnesses to this event – that to provide direction to the members that they were to not interact with any other witnesses or themselves, to sit – basically what I said was to have them sit down, shut up, and make notes, and not talk to one another or talk to anybody else. That they were going to have to account for what it is that had happened and they needed not to compare or exchange information with one another because they were going to be the investigation....
>
> Q With respect to the making of notes, did you give Corporal Robinson any indication as to what type of notes should be made?
>
> A I suggested he should make extensive notes, or excellent anyways is what I have here.[156]

Staff Sgt. Wright testified that he had recently reviewed the notes that Cpl. Robinson made of the incident. In his view they were very short and not up to his standard of "excellent." Officers have a duty to report, and he would expect that there would have been more notes than what there were.

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[156] Transcript, September 23, 2009, p. 39.

He told me that the four officers continued to work together on the same shift at the Airport sub-detachment for two or three weeks after the incident, before being transferred. He checked with them regularly to determine if they were all right, but had no discussions with them about the incident itself.

6. Chief Superintendent Bent's November 5, 2007, e-mail

On June 16, 2009, three weeks after the last witness at our evidentiary hearings testified, and three days before closing oral submissions were scheduled to begin, Commission Counsel received disclosure from counsel for the Department of Justice of a potentially significant e-mail.[157]

The November 5, 2007, e-mail (Exhibit 177) was written by Dick (Richard) Bent, Chief Superintendent, Deputy Criminal Operations Officer, RCMP, "E" Division. It was addressed to Al Macintyre, Assistant Commissioner, Criminal Operations Officer, RCMP, "E" Division. The e-mail referred to Superintendent Wayne Rideout, the officer in charge of the RCMP's Integrated Homicide Investigation Team that was conducting the criminal investigation into Mr. Dziekanski's death. It stated:

> From: Dick (Richard) BENT
>
> To: MACINTYRE, Al
>
> Date: 2007-11-05 13:46
>
> Subject: Media Strategy – Release of the YVR video
>
> Al, spoke with Wayne Rideout today about our strategy for the release of the video. He had a couple of concerns. First, he didn't think we should be providing any explanation for what was transpiring but instead just say the Inquest will take evidence under oath etc. I went through the rationale and said we need to have an explanation otherwise our detractors will put their own spin.
>
> Second, as we're going to have someone speak to this, he suggested that it should be someone other than Dale Carr otherwise we may lose the perception

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[157] The circumstances surrounding the late disclosure of this document can be found in the Transcript, June 19, 2009.

> of independence. He would rather have someone separate from IHIT do this. We both think a Use of Force expert would be ideal. Gregg Gillis has not been involved in this investigation so is independent. I suggest we have Gregg do the narrative of what is happening.
>
> Finally, spoke to Wayne and he indicated that the members did not articulate that they saw the symptoms of excited delirium, but instead had discussed the response en route and decided that if he did not comply that they would go to CEW. He has asked investigators for a synopsis and should have it by noon tomorrow.

The word "members" in the last paragraph of the e-mail refers to the four RCMP officers who dealt with Mr. Dziekanski at the Vancouver International Airport, and "CEW" refers to a conducted energy weapon, commonly referred to as a TASER.

When this e-mail came to light, I stated on the record that the delay in disclosing it was appalling. When the evidentiary hearings reconvened more than three months later on September 22, 2009, I stated:

> On its face, the e-mail appears to tell a significantly different story from the testimony I had already heard from the four RCMP officers. From their testimony, it is open to me to conclude that they had no discussion with each other while en route to the Airport, they did not develop a plan of action before arriving at the Airport, [and] the conducted energy weapon was deployed in accordance with RCMP policy and their training.
>
> However, the e-mail, if accurate, suggests that the officers did have discussions with each other while en route to the Airport, they did formulate a plan of action before arriving at the Airport, [and] they were contemplating deployment of the conducted energy weapon if Mr. Dziekanski did not comply, which might not be in accordance with the RCMP policy and training.
>
> Because of the significance of the new evidence at our June 19, 2009, hearing, I accepted Commission Counsel's recommendation that closing arguments scheduled to commence that very day be adjourned until today and that in the interim a thorough investigation be carried out into the circumstances surrounding the writing of this e-mail.[158]

As requested by Commission Counsel, the entire RCMP investigation file and other records originating from, received by, or in the possession of the RCMP or any civilian member of the RCMP relating to the Dziekanski matter were disclosed – approximately 18,000 documents. Based on the Commission's review of those documents, Commission Counsel called three witnesses to testify about the Bent e-mail, whose testimony I will now summarize.

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[158] Transcript, September 22, 2009, pp. 2-3.

a. Chief Superintendent Richard Bent

Chief Superintendent **Richard Bent** told me that Mr. Pritchard had initiated a court proceeding in the preceding days to have his video of the Dziekanski incident returned to him. The RCMP had decided to return the video to him within a few days, and quite a bit of time was spent at "E" Division Headquarters developing a communications strategy. From his viewing of the Pritchard video he realized that when it became public, viewers would feel that the RCMP officer deploying the conducted energy weapon had done so very quickly.

On the morning of November 5, 2007, Chief Superintendent Bent had an impromptu meeting with Deputy Commissioner Bass and Assistant Commissioner Macintyre respecting the media strategy. During that meeting, Chief Superintendent Bent mentioned the recent change in RCMP national policy respecting the use of conducted energy weapons with individuals displaying symptoms of excited delirium. Deputy Commissioner Bass asked what the four officers had said about what had happened. Chief Superintendent Bent realized that he had not seen any synopsis from the officers of why they responded the way they did, and it was important to get that accounting in order to develop the RCMP's media strategy surrounding release of the Pritchard video.

Following that meeting, Chief Superintendent Bent sent an e-mail at 10:01 a.m. to Chief Superintendent Dale McGowan, Operations Officer for the Lower Mainland district (which included the Richmond detachment) that stated (Exhibit 176):

> Dale, as I understand it we expect the video to be released later this week. We were talking about our communication strategy and want to get our powder dry.

> Can we get a synopsis of what the members' accounts were. Especially, why the CEW member went to TASER right away. The explanation is important in this case.
>
> I know IHIT is a bit strapped but it's important that we have an update by mid-day tomorrow if possible.

Chief Superintendent Bent then went into a meeting that lasted the rest of the morning. He then had a phone conversation with Supt. Rideout, who had apparently been briefed by Chief Superintendent McGowan on the request for a synopsis. Soon after that conversation, at 1:46 p.m., Chief Superintendent Bent drafted his e-mail to Assistant Commissioner Macintyre (quoted earlier), reporting on his phone conversation with Supt. Rideout.

Chief Superintendent Bent told me that the main thrust of his conversation with Supt Rideout dealt with what the RCMP response should be once the Pritchard video was released. Those matters are dealt with in the first and second paragraphs of his e-mail. He added:

> And then the third paragraph deals with – goes back to the original question I asked. And the reason we'd asked that was we wanted an explanation from the members, an accounting of why they took the action they did with Mr. Dziekanski. That was important for us in developing our media strategy. So that was in answer to that....
>
> And it – and again, my discussion with Superintendent Rideout was specifically did the members make any comment about noticing symptoms of excited delirium, and again, that was the term that we were using at that time, and whether that was part of their accounting, or their reasoning for using the CEW. And in fact, Superintendent Rideout indicated that he not – they had not indicated that or articulated that. And through our conversation, as best I recall, that was what he did tell me and I recorded that in that third paragraph.[159]

Chief Superintendent Bent was asked about his recollection of his conversation with Supt. Rideout, and about the accuracy of the statements in his e-mail:

> Q Are you comfortable this accurately reflects what you intended to say?

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[159] Transcript, September 22, 2009, pp. 12-13.

> A I think it reflects what I intended to say. Again, the context was primarily the issue of the media strategy and what the members had said as it played into that. I don't have a specific recollection of exactly the detail that Superintendent Rideout gave me either with respect to what his thoughts were with the media strategy that we had contemplated or with respect to the members' accounting. I don't have a really clear recollection of that. As I say, it was a year and half later that the e-mail came to light again and I – it was one in amongst many other things that were going on at the same time.
>
> Q Is there anything you wish to correct about this e-mail you wrote to your superior officer?
> A No. I believe that what I would have written here is what I believed was – accurately reflect the conversation I had with Superintendent Rideout....
>
> Q Are you confident you did your best to record accurately what you were told by Superintendent Rideout?
> A Yes, certainly. These are serious matters we don't take lightly, so yes, I would have –
>
> Q Thank you.
> A – done it to the best of my ability, yes.[160]

Chief Superintendent Bent told me that he never received the synopsis referred to in the e-mails. As things turned out, they did not need the synopsis for the media strategy. Given the verbal information he had received from Supt. Rideout about the members' accounting, they did not feel that they were going to use that information in any public statements when the Pritchard video was released.

He agreed that, in spite of his exhaustive search for documents, he was not aware of any other notes or reports suggesting that the officers had developed a plan while en route to the Airport. He had no subsequent conversations with Supt. Rideout about his (Chief Superintendent Bent's) interpretation of the gist of their phone conversation, or as to the sources of it. The primary purpose of his original question had been to develop a media strategy, and he did not pursue the other issue any further. As far as he knows, Supt. Rideout never received a copy of the Bent e-mail. He agreed that he certainly could have misunderstood parts of what Supt. Rideout said about the officers developing a plan en route to the Airport.

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[160] Transcript, September 22, 2009, p. 14.

b. Assistant Commissioner Al Macintyre

Assistant Commissioner **Al Macintyre** told me that he is second-in-command in British Columbia and is the officer in charge of Criminal Operations, overseeing all operational activities. He typically receives 100-200 e-mails a day. After he has dealt with an incoming e-mail, he will often delete it. He does not delete his outgoing e-mails – they are stored in his computer for 90 days, and then they are automatically archived in the RCMP's main server. He conducted an exhaustive search for documents relating to the Dziekanski incident and recovered 3,546 documents.

He said that when he searched his e-mail files, he did not recover the Bent e-mail. Since it was an incoming e-mail sent only to him, with no file number on it, containing hearsay information, he likely read it and then deleted it. He testified that he had no recollection of receiving the Bent e-mail and had no recollection of answering it, forwarding it, or taking any steps in response to its contents. He agreed that he never received any other information that might indicate that the four officers discussed their response en route to the Airport.

He agreed that a review of his e-mail records of the Dziekanski incident shows that he received or sent e-mails for just about every day during the first three months of the investigation, but there was a gap in the outgoing e-mails between November 1 and November 8, 2007 (with the Bent e-mail being dated November 5, 2007). He had no explanation for that gap, and the RCMP's informatics and forensic teams could not assist. However, some of his incoming and outgoing e-mails during this time period were recovered from other officers' e-mail records.

c. Superintendent Wayne Rideout

Superintendent **Wayne Rideout** testified that he recalled having a phone call with Chief Superintendent Bent on November 5, 2007, in which they discussed the strategy for release of the Pritchard video. He told me that he made a note of the conversation, which he read into the record as follows:

> 1:45 p.m. on the 5th of November. Phone to Chief Superintendent Bent. Media issue YVR. IHIT should not do "play by play" following release of YVR video. Optics inconsistent with independent review. He will advise.[161]

He added that there is a line in his notes that says, "Meeting with MROs scheduled for tomorrow."

He was not aware of the existence of the Bent e-mail until he saw it for the first time in June 2009. The first two paragraphs accurately reflect their discussion. With respect to the sentence in the third paragraph that says, "but instead had discussed the response en route and decided that if he did not comply that they would go to CEW," he testified:

> Chief Superintendent Bent is a highly respected member of the RCMP. He occupies an extremely demanding role within this region. He is someone that I personally respect a great deal. But the way he has portrayed my comments to him in that passage that I read out is wrong.[162]

Supt. Rideout said that IHIT found absolutely no evidence to indicate that the four involved members had any plan to deploy the CEW or made any plan collectively while en route.

C. RICHMOND FIRE-RESCUE

At 1:34 a.m. on October 14, 2007, the No. 4 Hall of Richmond Fire-Rescue received a dispatch to attend at the International Arrivals level at the Airport in relation to a 40-year-old male who had collapsed. Captain **Kirby Graeme** was in charge, and he assigned Firefighter **Brent Kopp** as driver, Firefighter **Glen Cameron** as backup, and Firefighter **Sonia Duranleau** as first responder designate, which meant that she had the responsibility to attend first to the patient and perform the first analysis of the patient.

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[161] Transcript, September 22, 2009, p. 76.

[162] Transcript, September 22, 2009, p. 77.

The No. 4 Hall is located at, and provides service to, Sea Island. The Airport is at the outer limits of the No. 4 Hall's service area. The usual response time to the Airport, with traffic congestion on Russ Baker Way and Miller Road, is seven or eight minutes. In this case they were directed to respond Code 3, which meant that lights and siren were activated, and they reached the International Terminal building in about six minutes because of the light traffic.

The driver (Kopp) remained with the truck, and Captain Graeme led the other two firefighters into the International Reception Lounge. Captain Graeme told me:

> Q When you entered the IRL, what did you see?
>
> A Across the way there was some Mounties standing by, and I could see when I got in there was people with security type jackets on.
>
> Q And you say you saw Mounties standing by, what do you mean?
>
> A Well, generally if it was from here to the back of the room, they – I – you could see them just standing. And the same with the security people, they were just standing. Nobody seemed to be doing anything.[163]

Captain Graeme later said that, from the time the firefighters arrived until the second BC Ambulance arrived, the four RCMP officers "were standing by, it looked like three on one, three together and then one guy standing alone. They weren't – they were not assisting the patient in any way."[164] The three officers standing together were about 10 metres away from Mr. Dziekanski, and the officer standing alone was about five metres away. He was asked to describe his reaction. He said that he saw it as being unprofessional: "To see a patient face down, handcuffed and not being tended to in some way, shape or form, I thought something's not right here."[165] He did not see a Securiguard employee kneeling down and checking Mr. Dziekanski's carotid pulse.

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[163] Transcript, January 27, 2009, pp. 37-38.

[164] Transcript, January 27, 2009, p. 42.

[165] Transcript, January 27, 2009, p. 50.

Firefighter Duranleau told me that when she first entered the International Reception Lounge, she saw the patient lying down on his chest in the prone position, flat to the ground, face down on the right, and looking up on the left, with his hands handcuffed behind his back.[166] There were some RCMP officers and some other people about 10-15 feet away. No one was touching the patient.

Firefighter Cameron told me that when he entered the International Reception Lounge, he saw Mr. Dziekanski lying on his stomach, with his face turned to the left, with his hands cuffed behind his back. Two or three RCMP officers were standing by Mr. Dziekanski's feet, but there was no one at his head. He agreed that when he arrived what he saw was a scene where people were not showing a lot of concern about Mr. Dziekanski's health or the danger of him dying. He said that positioning Mr. Dziekanski's head to the left was good, in order to keep the airway open and reduce the risk of choking on vomit. He told me that the reference in his October 27, 2007, written statement to the IHIT investigator to Mr. Dziekanski being in the recovery position was not accurate, but added, "He was in the best position that he could have been in for being in handcuffs."[167]

Captain Graeme agreed that if someone reported that the patient's skin had gone blue, or that the patient made snoring sounds, that would indicate that the person was monitoring the patient. He also agreed that if the officers upgraded the ambulance call from routine to Code 3, which would suggest that the patient was being monitored and that there had been a dramatic change in the patient's condition.

Captain Graeme told me that Mr. Dziekanski was lying on his stomach in the prone position, with his face looking left, his hands cuffed behind his back, and his legs extended straight behind him – he was not in the recovery position. He was motionless, he was pale and his eyes were open but not moving. He was unresponsive to the firefighters' verbal commands and the application of pain stimulus. As part of Captain Graeme's scene assessment, he had to ensure that the scene was safe for his crew. He asked one of the RCMP officers (he thought it was the Black officer, i.e., Cst. Millington) what had happened, and was told, "We TASERed him, and there was no response, nothing happened. So we TASERed him twice more and he's been face down."[168]

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[166] Firefighter Duranleau's handwritten notes, made later that morning, also described Mr. Dziekanski as being in the prone position.

[167] Transcript, February 18, 2009, pp. 55-56.

According to Captain Graeme, one RCMP officer (he thought it was the Black officer) told him that Mr. Dziekanski had been down for a few minutes before their arrival,[169] and an officer (he did not remember who) told him that they had been monitoring Mr. Dziekanski since he was hit with the TASER. He understood "monitoring" to mean checking on consciousness and breathing, and ensuring that Mr. Dziekanski did not drown on his vomit.

Captain Graeme had no concerns about his team's safety. He told one of the police officers (he was not sure which officer) that they needed to take the handcuffs off in order to properly assess the patient, but the RCMP officer replied, "He's been violent. We're not going to take the cuffs off." Captain Graeme told me that this frustrated him, because it is very difficult to do a proper assessment of a patient in Mr. Dziekanski's position:

> To properly assess our patients we – we put them in – we roll them onto their backs and now we can make sure that they have clear airways. We can see that they can have a rise and fall of the chest, if they're breathing correct – if they're breathing efficiently. It's easier to assess them properly. Also if we need to do any type of CPR, then now they're in the right position, on their backs.[170]

As a result, Captain Graeme instructed Firefighter Duranleau to begin her assessment of the patient. Firefighter Duranleau spoke to the patient, but got no response. She told me that one of the RCMP officers told her that the patient would not understand because he was Polish. She then squeezed the bones in the neck area as a pain stimulus check, but again got no response. She put her ear beside his mouth and watched his chest for signs of movement, but did not feel or hear anything. She then attempted to assess a radial pulse (which was difficult to do because of the handcuffs), but could not find any pulse, at which point Firefighter Cameron asked one of the RCMP officers if they could remove the handcuffs, and the officer responded that the patient was acting violently so they didn't want anybody else to get hurt. She then checked the patient's carotid pulse. Her assessment was that Mr. Dziekanski was unconscious, was not breathing, and had no pulse. She told me that she had no personal concern that Mr. Dziekanski was a threat to her safety. She did not receive any information from the RCMP officers or from Captain Graeme about Mr. Dziekanski's condition before she arrived, and was not told that he had turned blue or that a conducted energy weapon had been deployed against him multiple times.

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[168] Later in his testimony, Captain Graeme said he did not think it was the Black officer who said this.

[169] Later in his testimony, Captain Graeme said he did not think it was the Black officer who said this.

[170] Transcript, January 27, 2009, p. 39.

Firefighter Cameron told me that he observed Firefighter Duranleau taking Mr. Dziekanski's radial pulse. She told him that she did not get a pulse, so he directed her to take a carotid pulse. While she did that, he put his face near Mr. Dziekanski's face to see if he was breathing. He did not feel any breathing, and Firefighter Duranleau reported no carotid pulse. Firefighter Cameron did not check either the radial or carotid pulse, but did try a pain stimulus on Mr. Dziekanski's neck to test for his level of consciousness, but he was unresponsive. He was concerned about Mr. Dziekanski not breathing and wanted to get him onto his back in case they had to perform CPR or use the automated external defibrillator. He told me that he told one of the RCMP officers that he needed the handcuffs off right away because he didn't feel any breathing, and then added, "They indicated to me that he'd been quite agitated and was causing quite a commotion that they didn't want to take the handcuffs off him."[171]

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[171] Transcript, February 18, 2009, p. 33.

About 90 seconds after the firefighters arrived, the first BC Ambulance Service paramedics (basic life support[172]) arrived. Captain Graeme explained to them that Mr. Dziekanski had been hit with the TASER three times. The paramedics told the RCMP officers emphatically that they needed to have the handcuffs removed in order to assess the patient properly. One of the RCMP officers removed the handcuffs.

When the paramedics rolled Mr. Dziekanski over, Captain Graeme observed that Mr. Dziekanski had urinated through his pants. He looked very pale, with waxy-looking skin, and he had no colour in his face. He told me that he thought that Mr. Dziekanski was in cardiac arrest. And later added, "I didn't think that he was alive."[173] The paramedics began their protocols, Firefighter Duranleau (at the paramedics' direction) started to do compressions, and Captain Graeme prepared the automated external defibrillator. The paramedics put the defibrillator on, but the device announced "no shock advised." Captain Graeme explained to me that when the defibrillator is activated it will go through a sequence to determine whether it should shock the patient to restore the heart rhythm – it will only apply a shock in the case of two rhythms, ventricular tachycardia and ventricular fibrillation. The "no shock advised" reading was consistent with Mr. Dziekanski having no heart rhythm at all (i.e., asystole).

Captain Graeme told me that about one minute after the arrival of the first BC Ambulance Service paramedics, an advanced life support team from the BC Ambulance Service arrived. Firefighters Duranleau, Cameron, and Kopp did chest compressions on Mr. Dziekanski, on two-minute rotations for 20-25 minutes, until one of the advanced life support paramedics instructed them to stop, when the paramedic pronounced death after talking with an emergency department physician at Richmond General Hospital.

Captain Graeme was asked about the Airport's Emergency Response Service. He said that he was surprised that they did not attend this call. Since they are only 800 metres away (as opposed to the No. 4 Hall being four kilometres away), they always arrive first. He added:

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[172] In late 2007, the BC Ambulance Service adopted a change in terminology, from "basic life support" to "primary care" paramedics.

[173] Transcript, January 27, 2009, p. 42.

> The ERS staff, the firefighters out there, have been at every medical call that I've ever been to. They're there before we get there. A lot of times we wonder why we're even sent, because they've done all their assessments of the patients, got them onto – on oxygen and done everything that we would have done, only they've saved us – they would have saved us a trip. So they are at all medical calls that I've gone to at YVR.[174]

Firefighter Cameron told me that he has been involved in over 100 Code 3 calls to the Airport – just about all the time, the Airport's Emergency Response Service reaches the scene before the firefighters.

Captain Graeme was asked whether a delay in removing handcuffs affects survival rates:

> Q And the amount of time that elapsed between the time you arrived at Mr. Dziekanski's side and the time that the handcuffs were ultimately removed you stated was over a minute.
> A Yes, it was.
>
> Q When you're trying to administer medical care or save a victim's life, is a minute a medically significant amount of time?
> A Yes it is.
>
> Q Do survival rates drop for every minute that passes without medical attention?
> A To someone that's not breathing and with no pulse, yes, definitely.[175]

Captain Graeme agreed that there were several errors in the written incident report (Exhibit 13) he prepared after returning to the fire hall:

- To explain why it took more than five minutes to reach the scene, he recorded "traffic delay/congestion en route," when he agreed that there was no traffic congestion. He explained that this was one of the options on a drop-down menu, and he did not realize there was another (and more accurate) option of "outer edge of our response area";

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[174] Transcript, January 27, 2009, p. 44.
[175] Transcript, January 28, 2009, p. 54.

- In the Remarks portion of his report he stated, "Fortunately the patient had a rhythm that required no shock." He agreed that this statement did not mean anything and was an error, as Mr. Dziekanski had no heart rhythm. He later said, "When I said 'fortunately,' it meant that I was keeping in step with the procedures for the medical study that the doctors were doing, the cardiac doctors are doing."[176] This referred to a medical study then underway of people in cardiac arrest, in which some patients were given CPR for two minutes and others were given CPR for one minute, before analysis.

He was referred to Firefighter Cameron's written statement to IHIT investigators, in which he stated, "Everything was fine. Everything was controlled and so, to me, it looked like the RCMP had done their job." He disagreed with Firefighter Cameron's statement.

D. BC AMBULANCE SERVICE

Two BC Ambulance Service units attended the scene at the Airport. The first unit to arrive brought two Basic Life Support paramedics, **Allan Maciak** and **Mike Egli**. The second unit brought two Advanced Life Support paramedics, **Ronald Van Houten** and **Miles Randell**.

1. Basic Life Support paramedics

Mr. Maciak told me that they received the dispatch (a Code 3 for an unconscious patient) when returning to their station in South Richmond, and it took nearly 13 minutes to get to the Airport.[177] On that shift, Mr. Egli was the driver and he was the attendant. When they arrived curbside, a security guard told them that there was a male inside who was being aggressive, the police had to use the TASER on him, and he was handcuffed just inside the door. The two paramedics entered the International Reception Lounge together, with the stretcher between them.

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[176] Transcript, January 28, 2009, p. 55.

[177] According to Mr. Egli, they were dispatched at 1:34 a.m. and arrived at 1:47 a.m.

Mr. Maciak told me that as they walked across the lounge, Cpl. Robinson approached them and said that Mr. Dziekanski was being aggressive and throwing stuff, that they had to use the TASER on him and had laid him on his side and were monitoring his vitals. Mr. Maciak saw Mr. Dziekanski lying prone on his chest with his head tilted to one side. There were two or three RCMP officers and an Airport security man standing by Mr. Dziekanski's feet. He saw three firefighters standing along the left side of Mr. Dziekanski's prone body. He saw Firefighter Cameron reaching down trying to assess a radial pulse, and he added:

> It was obvious that, you know, his face – facial features, what you could see of his face, was bluish in colour and cyanotic. And so I asked Firefighter Cameron if this gentleman is breathing, and I don't recall what he said. I don't think he said anything at all. So at that point I got down and did my own assessment.[178]

According to Mr. Egli, when he entered the International Reception Lounge, three RCMP officers were standing 10-15 feet past Mr. Dziekanski. The closest one approached them as they entered. He saw three firefighters two to four feet to the right, down toward Mr. Dziekanski's legs. He told me his initial impressions of Mr. Dziekanski, while still 40-50 feet away:

> When I first saw him, when the door opened and I looked in, I could see – see him lying on the floor. I could tell that he had his hands behind his back and he was very cyanotic. He looked to me to be in dire need and looked more lifeless than anything.[179]

In the handcuffed position, Mr. Maciak could not be sure if Mr. Dziekanski was breathing, so he asked Cpl. Robinson if he could remove the handcuffs because they needed to get him onto his back. Cpl. Robinson told him that the male had been quite aggressive. Mr. Maciak repeated that they really needed to get Mr. Dziekanski onto his back, and Cpl. Robinson removed the handcuffs. Mr. Egli told me that he had no concerns about Mr. Dziekanski regaining consciousness and fighting, and he also said to the RCMP officer, "We need the cuffs off now," in a tone that he would expect it to be done.

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[178] Transcript, March 26, 2009, p. 27.

[179] Transcript, March 26, 2009, p. 74.

The two paramedics rolled Mr. Dziekanski onto his back. Mr. Maciak said, "Oh, look at his colour." Mr. Egli found that Mr. Dziekanski was not breathing and had no carotid pulse. He yelled at one of the firefighters, "Get the damn oxygen on him now, high flow, 15 litres on a non-rebreather mask."[180] Mr. Maciak testified:

> Q Let's go through a number of your observations. Tell us about eyes.
> A Closed. He was essentially cyanosed. His lips were blue. His tongue was at the front of his mouth. You could see it kind of protruding from the teeth a little bit. It was blue. He – incontinent with urine. Unresponsive. I don't want to get too descriptive here to offend anybody.
>
> Q That's fine. And his vital signs?
> A Absent. There was none.
>
> Q What was your impression about his state of being?
> A Mr. Dziekanski was dead.[181]

Nevertheless, Mr. Egli inserted an oral airway, Firefighter Duranleau began chest compressions and Mr. Maciak set up the automated external defibrillator. When it analyzed the heart rhythm and advised no shock, they focused on CPR, and Mr. Maciak advised the Advanced Life Support unit that was en route that they had a cardiac arrest. He asked Cst. Millington about Mr. Dziekanski having been hit with the TASER, and Cst. Millington responded that they had cycled him three times. When the Advanced Life Support team arrived they took over, and Mr. Maciak provided support.

Mr. Maciak told me that normal respirations should be almost quiet. In the case of an unconscious patient, muscle control in the tongue may be lost, with the tongue falling back into the pharynx, blocking the airway. This may result in a snoring respiration. Students in basic first aid and CPR courses are taught two responses when they hear a snoring respiration – a jaw thrust and a head-tilt/chin-lift.

Mr. Maciak was asked what cyanosis means. He told me:

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[180] Transcript, March 26, 2009, p. 91.

[181] Transcript, March 26, 2009, p. 29.

> It's a bluish colouration of the skin. It's caused by cells and tissues not having enough oxygen, so that circulation process has been impeded somehow. The skin isn't getting enough oxygen....
>
> The body's pretty smart. If it's having trouble, it'll sort of compensate and – to keep the vital organs running best. So you'll usually notice it on the ears, the fingertips, first. And that can usually be corrected with a little bit of oxygen. By the time it gets to sort of central cyanosis in the lips and the tongue, you know, and the entire body, it's pretty hard to reverse at that point. That involves an Advanced Life Support paramedic to usually help turn that around.[182]

Mr. Maciak said that, from beginning first-aid classes that teach the ABCs, students are taught that if you have a problem with A (airway), you resolve it before moving to B (breathing), and if you encounter a problem with breathing, you resolve it before moving to C (circulation). When he saw the firefighter assessing Mr. Dziekanski's pulse, he assumed that A and B were fine because they had taken no critical interventions to deal with the airway or breathing.

Mr. Maciak agreed that in the two minutes between their arrival and the arrival of the Advanced Life Support team, he and Mr. Egli had been able to assess the airway, breathing, and circulation; begin CPR ventilation and chest compressions; and analyze once with the automated external defibrillator. He was asked:

Q	Would the Richmond Fire Department firefighters have the training to take those steps and the equipment?
A	They – the AED and CPR training they have is identical to what we have, yes.
Q	So in the two minutes they were with the patient, they could have done all the things that you and your patient [*sic*] did before the Advanced Life Support arrived?
A	They could have, yes.[183]

However, when subsequently asked whether the firefighters' actions were appropriate, he said, "You know, I can't answer for them. I really don't know. Personally I would have liked to have seen something being done to Mr. Dziekanski, you know. Again too, I can't comment on what they had time to do and what they didn't have time to do."[184]

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[182] Transcript, March 26, 2009, p. 14.

[183] Transcript, March 26, 2009, p. 43.

Mr. Maciak was questioned about a statement he gave IHIT investigators on January 15, 2008, in which he stated:

> The biggest shock came to me was that you know basically that the, you know the fire department was doing nothing. Like no critical intervention, no airway, no nothing, and it, and it was – not that it was obvious when he was in that position but as soon as you rolled him over you could tell then, it was pretty obvious he was lifeless. And, and in my, my first impression is you know he had been down for a little while, that this wasn't something that just happened here.
>
> Not to get centrally cyanose. Most people uh first will get periphery, peripheral cyanosis in their fingertips, maybe their ear tips, but he was centrally cyanose. His tongue, his lips, his whole face and chest were blue from lack of oxygen.[185]

He agreed with the suggestion that what he was referencing in his testimony was that, given how Mr. Dziekanski appeared to him, he would have expected aggressive medical intervention at that stage, but saw none being performed.

Mr. Egli told me that, although he did not ask the firefighters why oxygen had not been started before their arrival, he was angry. "I was very upset of what I experienced when we first got there and I didn't think it would be the best place to air it."[186] He explained to me that, given Mr. Dziekanski's condition (being as cyanosed as he was and lifeless), he was angry that no medical procedures were being done. He voiced his concern to several of his supervisors, and understood that one of them had talked to the Richmond Fire-Rescue staff about it.

2. Advanced Life Support paramedics

Mr. Randell told me that he was the driver that morning, and Mr. Van Houten was attending. When they arrived at the International Reception Lounge (about two minutes after the basic life support paramedics), Mr. Dziekanski was supine (i.e., lying on his back) and CPR was underway. He connected their manual cardiac monitor, which reported that Mr. Dziekanski was asystole, meaning that there was an absence of electrical activity in the heart. He said that asystole is the most difficult cardiac rhythm from which to recover a pulse – some jurisdictions will not even attempt resuscitation on someone who is in asystole, because the possibility of regaining a pulse is very, very slight if any at all. He said that it usually takes a patient in Mr. Dziekanski's situation between two to five minutes, or perhaps up to 10 minutes, to go from a profusing heart rhythm (i.e., a rhythm with a pulse) to asystole.

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[184] Transcript, March 26, 2009, p. 44.

[185] Transcript, March 26, 2009, pp. 51-52.

[186] Transcript, March 26, 2009, p. 81.

He told me that Mr. Dziekanski was quite pale, was incontinent, and appeared lifeless. He did not observe any cyanosis, but CPR had been underway for several minutes and that usually corrects cyanosis fairly quickly.

Nevertheless, Mr. Randell started to initiate intravenous treatment and medications, and Mr. Van Houten initiated endotracheal intubation, which involved passing a breathing tube into the lungs so that they could more efficiently ventilate and oxygenate the patient and, if necessary, give medications directly into the lungs. They followed the normal protocol for asystole, administering epinephrine (which causes the blood vessels in the periphery to contract and artificially increase the patient's blood pressure) and atropine (which blocks some of the nerve impulses in the nervous system that may cause the heart to beat very slowly). Because Mr. Dziekanski was fairly young, they also administered sodium bicarbonate to make medications more effective and to counteract the acidosis that will occur when someone is not breathing and their heart is not beating.

Mr. Van Houten agreed that, given the circumstances before them, especially Mr. Dziekanski's initial heart rhythm being asystole, he did not expect that they would be successful in reviving him. He told me that after 20 minutes of resuscitation attempts, he consulted by phone with a Richmond physician, and she gave orders to discontinue resuscitation, at which point Mr. Van Houten pronounced Mr. Dziekanski dead.

Mr. Van Houten said that agonal breathing, which can arise in a pulseless patient, could sometimes sound like snoring. As the body moves into hypoxia (i.e., lack of oxygen), the patient can have seizure-like activity such as body spasms and leg kicking, which might resemble struggling.

E. EXPERT TESTIMONY

Following the evidence of the four RCMP officers who dealt with Mr. Dziekanski, I heard several witnesses give expert evidence on the following issues:

- ***Video analysis*** – three of the four RCMP officers testified that after Mr. Dziekanski picked up the stapler, he stepped toward them. Cst. Rundel said that Mr. Dziekanski stepped forward with his left foot. Cst. Millington testified that Mr. Dziekanski was in a combative stance and was approaching the officers with, he believed, the intent to attack. Cpl. Robinson testified that Mr. Dziekanski took a step forward. Although this forward movement is not obviously apparent when viewing the Pritchard video, counsel for one of the officers tendered an expert in forensic video analysis to establish that the video does in fact support the officers' testimony. Counsel for one of the other participants tendered two other experts to challenge that opinion.
- ***Conducted energy weapon data download*** – the police officer who downloaded the data from the conducted energy weapon used in this incident at the request of the Integrated Homicide Investigation Team testified as to his findings.
- ***Translation of Mr. Dziekanski's statements from Polish into English*** – an interpreter testified as to his translation of Mr. Dziekanski's statements, as captured on the Pritchard videos.
- ***Use of force*** – the four RCMP officers testified that when Mr. Dziekanski picked up the stapler and turned toward them holding the stapler at chest height with the other hand in a fist, he displayed combative behaviour. They told me that, according to RCMP policy and their training, this subject behaviour justified deployment of the conducted energy weapon. Four use-of-force experts testified to explain RCMP policy and training respecting the use of force (with particular attention to deployment of a conducted energy weapon) and to offer opinion evidence respecting the four officers' use of force during this incident.

1. Video analysis experts

a. *Grant Fredericks*

Grant Fredericks worked in television between 1983 and 1987. In 1988 he joined the Vancouver Police Department and, as a constable, assisted the Investigations Division in the examination and processing of video evidence. In 1997, he became coordinator of the department's Video Unit. In 2000 he left policing and joined U.S.-based Avid Technology's Forensic Video Division, managing its forensic video development business for seven years. Since 2006 he has operated a forensic video analysis consulting business. He is an instructor at the FBI National Academy, an advisor to the International Association of Chiefs of Police, a panel member for the U.S. National Institute of Justice, an adjunct instructor for the University of Indianapolis, and principal instructor for the non-profit Law Enforcement and Emergency Services Video Association. More than 60 U.S. and Canadian courts have accepted him as an expert witness in forensic video analysis.

I accepted Mr. Fredericks as an expert in forensic video analysis. I was not prepared to qualify him in photogrammetry, because it appears that different experts use this term in quite different senses. I do accept his expertise in various aspects of photogrammetric measurement, such as digital compression technologies and image stabilization techniques. He described what he does this way:

> I'm using observation, I'm using scientific tools, I'm using my understanding of television engineering and compression, and image analysis to form an observational opinion and then to support that with a validated measurement of the number of pixels.[187]

From Mr. Fredericks' expert report (Exhibit 158) and his testimony during the evidentiary hearings, I understand that there were three elements to his analysis. First, the Pritchard video posed challenges for him because of its relatively low-quality resolution, Mr. Pritchard's movements while filming the incident, the shakiness of the images due to the camera being hand-held, and the zooming in and out while filming.

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[187] Transcript, May 25, 2009, p. 14.

Using several techniques, including a reverse projection process, Mr. Fredericks was able to stabilize the image, as he described:

> The stabilized result, included as a video attachment to this report, locks non-moving objects within the field of view of the camera so that they retain [*sic*] relatively still even while the camera is in motion. The stabilized result allows the viewer to see the movement of each of the people in the scene without the distraction of the up and down and in and out motion of the camera.[188]

Second, Mr. Fredericks isolated a three-second segment of the Pritchard video immediately prior to deployment of the conducted energy weapon (00:03:46:24-00:03:49:21). It shows Mr. Dziekanski with his back to the camera, with a counter between him and the camera, so he is visible from about elbow height upward. He is facing the four RCMP officers, who are spread out in a crescent in front of him. Mr. Fredericks created a three-second video "loop" and played the segment over and over again. From this repetitive viewing, he told me that he was able to discern the following movements by Mr. Dziekanski, which he described in his written report as follows:

> At 00:03:46:24 DZIEKANSKI is standing so that his left shoulder is at the 430th pixel from the left side of the image in the stabilized view....[189]
>
> DZIEKANSKI moves forward and to his right. His body shifts to the right as his weight moves from his left side to his right side, consistent with moving his right foot forward with his body weight moving to his right foot.
>
> At 00:03:47:23, one second after the previous image, DZIEKANSKI has moved so that his left shoulder is positioned at the 459th pixel from the left in the stabilized view.
>
> A reference for this motion can be seen by comparing the position of the green coloured post on the wall in the background with the position of DZIEKANSKI's right shoulder. Clearly, he has moved to his right to a position where his elbow is blocking partial view of the post.

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[188] Exhibit 158, p. 11.

[189] Pixels are picture elements, similar to dots in a photographic image. Each image referred to by Mr. Fredericks has 640 pixels from left to right and 480 pixels from top to bottom.

> At 00:03:48:23, one second after the previous image, DZIEKANSKI has shifted his weight to his left as he moves forward. This motion is consistent with stepping forward with his left foot....
>
> At 00:03:49:21, one second after the previous image, he shifts his weight to the right again as his right leg moves forward toward the officers. One can see that his left shoulder is further away from the light reflected sign and his right shoulder is closer to the green post when compared to the previous image....
>
> Note that each step is exactly one second apart, showing a methodical movement forward.[190]

From these observations of the stabilized image (a two-dimensional view), and his 25 years' experience in forensic video analysis, he concluded that during this three-second period Mr. Dziekanski took three distinct steps forward. However, he could not tell me how far forward Mr. Dziekanski moved:

Q	The only thing that you're able to do with the methodology that you have chosen is to inform this Commission that Mr. Dziekanski moves forward but you can't say by what distance?
A	Yeah, that's correct.
Q	It could be an inch?
A	I don't want to guess on how far he's moved forward. I don't – I can't say.
Q	No. But it can be a very, very small distance?
A	Yeah, I – I don't want to comment on how far. I don't think that would be fair. I couldn't really comment on that.[191]

Mr. Fredericks agreed that his opinion about forward movement is based only on his observation of the stabilized video. Because of the counter, he could not see Mr. Dziekanski's legs or feet, and he has no special expertise in biomechanics or the study of human motion.

Third, Mr. Fredericks explained that because the camera was aimed horizontally at about head level, it is difficult to observe small changes in size as a person moves

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[190] Exhibit 158, pp. 11-12.

[191] Transcript, May 25, 2009, p. 82.

away from the camera. In addition, the camera zoomed out during this three-second segment. Consequently, he resorted to applied reverse projection/photogrammetry to assist with a scientific analysis of positional changes by assessing the relationship between Mr. Dziekanski and fixed objects in the scene. As he stated in his report:

> In order to determine if DZIEKANSKI is actually in motion, a calculation showing the percentage of change in his size compared to the percentage of change in the size of the fixed counter will help to show whether DZIEKANSKI is actually moving away from the counter or if he is simply adjusting his weight from side to side.[192]

To do this, Mr. Fredericks compared two images, one at the beginning of the three-second segment (Image A) and the other at the end of the three-second segment (Image B). For each image, he measured a set distance on the movable object (i.e., Mr. Dziekanski) and on a fixed object (i.e., the counter). For Mr. Dziekanski, he measured from the top of the collar on Mr. Dziekanski's jacket down to the bottom of the jacket. However, since the counter hid the bottom of the jacket, Mr. Fredericks measured down to the lowest visible point on the jacket. For the counter, he measured from the top of the counter to the bottom of the centre cupboard on the counter.

Mr. Fredericks found that during the three seconds, the fixed points on the counter went from 105 pixels in length to 82 pixels (due to the camera zooming out), a reduction to 78.09 percent of its length.[193] However, the fixed points on Mr. Dziekanski's jacket went from 89 pixels in length to 66 pixels, a reduction to 74.16 percent of its length. From this he concluded:

> The difference in change between DZIEKANSKI's collar and the counter between Image A and Image B changes by more than 4%, which is four times the margin of error.

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[192] Exhibit 158, p. 13.

[193] To test this methodology, Mr. Fredericks also measured the distance between two lines on the wall in the background, and found that, at the end of the three-second segment, the space between the lines reduced to 77.28 percent of the space at the beginning. Since this was less than one percent different from the reduction in the length of the counter, he concluded that there was a margin of error of less than one percent.

> This scientific analysis shows that DZIEKANSKI is clearly moving away from the camera and toward the officers in the three seconds between Image A and Image B.[194]

When asked during the evidentiary hearings what conclusion he drew from these findings, he said:

> A Well, my conclusion was only that it validated my observations of the video that Mr. Dziekanski was moving away from the camera, not by how much but simply he was moving away....
>
> THE COMMISSIONER: You cannot say whether it's one step or not? ....
>
> A Well, I can't say – the validation – this doesn't tell me anything about steps or distance, just that he's moved away between the images. This doesn't measure steps.[195]

b. Mark Hird-Rutter

Mark Hird-Rutter has worked continually in the field of photogrammetry since graduating from the British Columbia Institute of Technology in 1976. In 2002 he joined BCIT as a full-time instructor in the Geomatics Department, teaching photogrammetry and digital mapping. He is a Certified Photogrammetrist through the American Society of Photogrammetry and Remote Sensing. I accepted Mr. Hird-Rutter as an expert in photogrammetry, and his written report was entered as Exhibit 159.

Mr. Hird-Rutter was retained to analyze the methodologies used by Mr. Fredericks, when he measured the changes in length of Mr. Dziekanski's coat and the counter over the three-second segment in order to determine whether Mr. Dziekanski moved forward. His ultimate opinion is set out at page 11 of his report:

> The methodologies that were used in Mr. Fredericks' report do not follow the rigours of the Science of Photogrammetry and it would be wrong to use them to determine the movement of Mr. Dziekanski either forwards or backwards.

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[194] Exhibit 158, p. 15.

[195] Transcript, May 25, 2009, p. 44.

Mr. Hird-Rutter had several criticisms of Mr. Fredericks' analysis, including the following:

- Perspective geometry is used to determine the position of Mr. Dziekanski in two images, but determining distances using perspective geometry is mathematically very weak.
- Only two sets of measurements are used to determine the scale change between images (when the industry standard is at least 10), and only one set of measurements is used to determine the relative size of Mr. Dziekanski from one image to the next.

He described in his report his most significant criticism of Mr. Fredericks' "flawed methodology":

> The top of Mr. Dziekanski's collar is identifiable in both images. There are no other points on Mr. Dziekanski's back that are clear in both pictures. Therefore Mr. Fredericks does not have two points on Mr. Dziekanski to create the perspective geometry.... In the diagram [in Mr. Hird-Rutter's report] Mr. Dziekanski could be in any of the positions shown and the measurements would still be the same. It would be wrong, using photogrammetry, to say that Mr. Dziekanski moved either forwards or backwards on these measurements.
>
> It is impossible to make photogrammetric perspective measurement without two identifiable points on the object that is being measured. One cannot do this.[196]

c. *Duane McInnis*

Duane McInnis graduated from Carlton University in 1972 in mechanical engineering. He is a registered professional engineer in British Columbia and Ontario, and is the founder and senior engineer in MEA Forensic Engineers and Scientists, Canada's largest forensic engineering and scientific firm. He has been accepted as an expert witness 140 times in incident and accident reconstruction, and has researched and lectured on two-dimensional photogrammetry. I accepted him as an expert in the field of mechanical engineering, in incident and accident reconstruction, and with an applied specialty in forensic photogrammetry. His written opinion was filed as Exhibit 160.

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196 Exhibit 159, p. 10.

Mr. McInnis viewed the stabilized three-second segment of the Pritchard video prepared by Mr. Fredericks. He studied the qualitative movement of Mr. Dziekanski by comparing his position to fixed objects in the images (such as the counter and the parallel lines on the back wall). He found that Mr. Dziekanski was moving at almost all times. "He was swaying left and right, his shoulders were rising and falling, and his head was rising and falling."[197]

He told me that in order to use reverse projection photogrammetry to determine if there is motion:

> There must be two discrete points on Mr. Dziekanski that have the same angular orientation with respect to the camera, and these two points must be visible in both images. This requires that the two points on each image be known to be the same two points on the object. The contrast between the top of the jacket against the neck, and the bottom of the jacket against the trousers, may suffice. Failing that, there should be two points with a clear delineation, such as the top of the collar and a different coloured belt, button, or object on the back of the jacket, visible in both images. The distance between these two points must remain constant in the object space. Of course, there must be no folding or elastic deformation of the fabric between the two measurements.[198]

Mr. McInnis said that one cannot see the bottom of Mr. Dziekanski's jacket in the images, and for that reason Mr. Fredericks amended his report to say that he measured the distance between the top of the collar and the top of the counter. The bottom point is totally meaningless for any photogrammetric analysis, because it is unrelated to Mr. Dziekanski.

He concluded that Mr. Fredericks' opinion (that Mr. Dziekanski moved toward the officers) is not technically supportable because of measurement errors and the failure to use two measurement points on Mr. Dziekanski's jacket. Further, since Mr. Dziekanski is oscillating up and down, as well as side to side, Mr. Fredericks should have conducted his measurements on two images where the vertical positioning is identical, at the same point on the motion.

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[197] Exhibit 160, p. 3.

[198] Exhibit 160, pp. 4-5.

2. Conducted energy weapon data download

The RCMP's Integrated Homicide Investigation Team asked Constable **Craig Baltzer** of the Delta Police Department to download the data from the conducted energy weapon used against Mr. Dziekanski. Cst. Baltzer is a 23-year veteran with the Delta Police. He is a certified firearms trainer and provincial use-of-force instructor, and has been certified by TASER International, Inc. as a Master TASER Instructor and TASER Armorer. I also accepted Cst. Baltzer as an expert in the use of, and in instructing on the use of, TASER conducted energy weapons.

The download report (Exhibit 96) shows that the weapon was deployed five times, for 6 seconds, 5 seconds, 5 seconds, 9 seconds, and 6 seconds, respectively, for a total duration of 31 seconds. In his first of two reports (Exhibit 97), Cst. Baltzer stated, "There is no way to determine through this device to measure the duration of time that the client experienced the effects of the TASER X26E [p. 3]."

Cst. Baltzer told me that if one of the probes attaches to the subject's skin or adjacent clothing, but the other does not, no electrical current would be transmitted into the subject's body. When that happens, the weapon will emit a distinctly audible clacking sound. Sometimes, one probe will attach to the skin but the other probe will attach to a shirt or jacket, and if the subject moves about, that part of the shirt or jacket may flap away from and against the skin, causing an intermittent transmission of electrical current into the subject. Based on his review of IHIT photographs showing a probe and filament wires attached to the bottom of a shirt, this appears to be what happened in the Dziekanski incident.

To determine if there were intermittent discharges of current into Mr. Dziekanski's body, Cst. Baltzer watched the Pritchard video and listened to the audio. He summarized those observations in his second report (Exhibit 97). He told me:

- The first deployment lasted six seconds. After one second of normal discharge, he heard clacking that indicated intermittent discharge of electrical current thereafter. In other words, the weapon was having some, but not full, effect on Mr. Dziekanski.

- The second deployment began one second after the first deployment ended, and lasted for five seconds. During the first one-and-a-half to two seconds clacking is heard, but not thereafter, from which he concluded that Mr. Dziekanski appeared to be under the influence of the weapon.
- The third deployment began 12 seconds after the second deployment ended, and lasted for five seconds. He heard no clacking sounds, which indicated that Mr. Dziekanski was under the effect of the weapon for the full five seconds.
- The fourth deployment (in push-stun mode to Mr. Dziekanski's upper back area) began four seconds after the third deployment ended, and lasted nine seconds. He could not determine whether there was any intermittent discharge.
- The fifth discharge (in push-stun mode to Mr. Dziekanski's upper back area) began two seconds after the fourth deployment ended, and lasted six seconds. He could not determine whether there was any intermittent discharge.

Cst. Baltzer told me that the wire filaments connecting the TASER cartridge to the two probes can offer useful information about, for example, whether they had been broken during deployment, whether the probes had been fully extended or missed the subject, whether there was a burn or short circuit indicating that no electrical current was delivered, and what the probes hit. He did not receive filaments or probes in this case, although he discussed with the Integrated Homicide Investigation Team the types of information that can be obtained from them.

He told me that subjects react differently to a conducted energy weapon. Some fall down immediately, some take a few steps before falling down, and others have no apparent reaction at all. From his review of the Pritchard video, it was his opinion that the first deployment of the weapon caused Mr. Dziekanski to lose his balance and fall down. He agreed that in response to the first deployment, Mr. Dziekanski reached for his chest, which could be a common reaction when the weapon is used in probe mode.

Cst. Baltzer agreed that Mr. Dziekanski's flailing and hyperactive reactions, while on the floor and during the push-stun mode deployments, were consistent with involuntary spasm caused by the deployment of the weapon.

3. Translation of Mr. Dziekanski's statements from Polish into English

Mr. **Kris Barski** testified respecting his translation of Mr. Dziekanski's statements, as recorded on the first and second segments of the Pritchard video. His translations were filed as Exhibit 31.

The first segment of the video records Mr. Dziekanski's actions in the International Reception Lounge before the RCMP officers arrived. He is seen in an agitated state, throwing a laptop computer on the floor and a folding wooden table against the glass partition, breaking both. During this video, he makes the following statements at the following times:

0:30	I will trash this office
0:40	Fuck off
1:11	I will smash the glass, and I will smash the glass here. And you will see
1:32	What did you say? You will not let me?
1:38	You will not let me?
1:44	For fuck's sake. I will sue you and everybody else.
1:50	Umh!
1:54	Fine, fine [indecipherable] we are in a different country so [indecipherable]
2:13	I will smash the entire desk. I will smash the entire desk. [indecipherable] trouble.
2:20	Leave me alone everybody. Go away I said
2:32	For fuck's sake.

The second segment of the video records the interaction between Mr. Dziekanski and Ms. Ashrafinia, and between him and the four RCMP officers. He makes the following statements at the following times:

0:06	*[While Ms. Ashrafinia is talking to him]* How long do I still have to wait.
2:06	*[While Mr. Dziekanski is just inside the swinging glass doors (which are open), moving chairs around. Several Airport security officers are about ten feet outside the swinging glass doors, on the public side]* So you will not let me go? You will not let me out of here?

3:00	*[As the four RCMP officers walk across the public area, toward the swinging glass doors, and Mr. Dziekanski looks in that direction]* Police, Police
3:43	*[After Cpl. Robinson points toward the counter and Mr. Dziekanski moves toward the counter]* Leave me alone. Leave me alone! Did you become stupid? *Or* Are you out of your mind? *Or* Have you lost your minds? *Or* Have you gone insane? Why?
3:50	[*Immediately before Cst. Millington deploys the conducted energy weapon against Mr. Dziekanski*] Police, Police
4:30	[*While Mr. Dziekanski is on the ground and the four RCMP officers are attempting to restrain him*] [Indecipherable]

Mr. Barski told me that his impression, from considering Mr. Dziekanski's manner of speaking, his demeanour, and the context of the events seen on the video, was that Mr. Dziekanski was confused and scared, not angry.

4. Use-of-force experts

a. Sergeant Brad Fawcett

In March 2008 **Sgt. Brad Fawcett** of the Vancouver Police Department prepared a 38-page report for the Integrated Homicide Investigation Team respecting the four RCMP officers' use of force in their interaction with Mr. Dziekanski. His report was filed as an exhibit (Exhibit 89), and he testified during our evidentiary hearings.

Sgt. Fawcett has a B.A. degree from Simon Fraser University and is currently enrolled in an M.A. program in criminal justice at University College of the Fraser Valley. He became a police officer in 1990, and was promoted to sergeant in 2004. He was a full-time use-of-force instructor for seven years and is currently seconded to the Justice Institute of British Columbia as an instructor in use of force and physical fitness. He researched, developed, and implemented the Provincial Use of Force Instructor Certification Course and the Integrated Use of Force Instructor Certification Course at the Justice Institute. I accepted him as an expert in the use of force by police officers in British Columbia, including the use of TASER, and as an expert in the training of police officers in the use of force in British Columbia, including TASER.

In his report, Sgt. Fawcett summarized the written statements of 20 civilian witnesses, the written statements of the four RCMP officers, the Canada Customs video, the Airport Authority video and the Pritchard video, and Cst. Baltzer's conducted energy weapon data download report. Pages 26-38 of his report set out his "Use of Force Analysis," which I will summarize below:

- The officers were in the legal execution of their duties and acting on reasonable grounds.
- The officers were aware that they were responding to a call in which the subject of the complaint had demonstrated a willingness, ability, intent, and means to violently damage property.
- The officers walked purposefully toward the swinging glass doors and are seen on the Pritchard video standing in close proximity to Mr. Dziekanski with relaxed but ready postures with their hands down at their sides. They maintain a "reactionary gap" – four to six feet from an apparently unarmed subject, providing the officers with sufficient time to analyze, evaluate, plan, and initiate a physical response to threat stimulus.
- The officers' initial attempts at communicating with Mr. Dziekanski employed the force response options of Officer Presence (four uniformed officers) and Communications (informal greeting), in an apparent attempt to calm him.
- The officers perceived Mr. Dziekanski to be aggressive, combative, and agitated, and these perceptions were supported by the Pritchard video. They had reasonable grounds to believe that Mr. Dziekanski had demonstrated violent behaviour immediately prior to their arrival.
- The officers "triangulated" on Mr. Dziekanski – i.e., the practice of containing a suspect in such a manner that it makes the problem area as small as possible having due regard for the tactical environment in which the encounter occurs. This type of triangulation positioning is consistent with law enforcement training across North America. It assists officers in generating voluntary compliance by reducing options available to the subject, and is a tactic that forces subjects to choose which officer he or she will attack.
- Cpl. Robinson reportedly gave Mr. Dziekanski commands to place his hands on the counter, and pointed at it. Mr. Dziekanski armed himself with a stapler from the counter, with no evidence to suggest that he intended to use it for an innocent purpose. The officers' reaction and statements supported their belief that he possessed the stapler for use

as a weapon of opportunity. A stapler held in a fist maintains the integrity of the fist upon impact, adds weight to the punch, and provides a variety of impact surfaces. Mr. Dziekanski's behaviour is classified as Assaultive – he had the apparent means, ability, intent, and opportunity to assault the officers or anyone else who entered into the immediate area.

- The Pritchard video shows that the officers increased the reactionary gap. This is consistent with training for dealing with armed subjects demonstrating pre-assault cues, which include clenching fists, a "thousand yard" stare, jaw clenching, verbal threats, etc.
- According to the National Use of Force Framework, a subject is assaultive if he or she attempts to apply, or applies force to any person; attempts or threatens by an act or gesture, to apply force to another person; if he/she has, or causes that other person to believe upon reasonable grounds that he/she has, present ability to effect his/her purpose. Examples include kicking and punching, but also include aggressive body language that signals intent to assault.
- Four seconds after Mr. Dziekanski picked up the stapler, Cst. Millington deployed the conducted energy weapon, which is classified as an Intermediate Weapon. Canadian police officers are instructed to consider the use of Intermediate Weapons when confronted by subjects demonstrating behaviours that are described as Active Resistant, Assaultive, or Grievous Bodily Harm or Death.
- It would have been reasonable for the officers to consider use of a conducted energy weapon, given the broadcast information of an intoxicated, aggressive, and violent male. The use of other Intermediate Weapons, such as pepper spray, could be precluded as ineffective or inappropriate – pepper spray has been shown to have a significant failure rate when used on intoxicated, mentally ill, or goal-oriented subjects, and in this type of closed environment, there is a risk of contamination.
- The use of batons would have required the members to penetrate the reactionary gap, thereby placing themselves within striking distance of Mr. Dziekanski, and would have prevented Cst. Millington from acquiring a target for deployment of the conducted energy weapon if baton use was ineffective.
- The officers appear to have precluded Physical Control (e.g. superior strength, joint locks, levers, etc.) based on the facts that Mr. Dziekanski was armed with a blunt object (stapler) and had previously demonstrated violence. Engaging the subject in a physical struggle would have been contrary to training respecting the "One-Plus-One

Theory," which dictates that an officer respond to subject behaviours with a force-presence option one level greater than that demonstrated by the subject.

- Cst. Millington's suspicion that Mr. Dziekanski might be suffering from excited delirium appears reasonable, given the behaviours he demonstrated prior to and during his encounter with the officers. Excited delirium is classified as a medical emergency and current research has supported police tactics, which encourage controlling subjects rapidly so that medical health professionals can intervene as soon as possible.
- Three of the officers reported that Mr. Dziekanski appeared to be affected by deployment of the conducted energy weapon, but he remained standing and continued to be assaultive, appearing to fight through the weapon. The Pritchard video supports the officers' version of events. After Mr. Dziekanski fell to the floor, Cst. Millington is seen moving toward him. This is consistent with training and is intended to prevent the probes from being dislodged and/or the filaments from breaking.
- The perception of the officers was that they were forced to wrestle the deceased to the ground. This perception is not supported by the Pritchard video, but the discrepancy is minor and easily understood.
- The conducted energy weapon might not have been making effective contact with Mr. Dziekanski – one of the probes likely embedded in Mr. Dziekanski's loose jacket or shirt.
- Cst. Millington reported that he deployed the weapon a second time because the first deployment did not have the desired effect. The officers reported that Mr. Dziekanski was actively resisting their attempts to gain control of his arms by "turtling-up," a type of resistance that poses significant concerns and challenges to police officers because the subject's hands are typically out of sight and close to their waist, where subjects typically conceal weapons.
- Cst. Millington cycled the weapon a third time at Cpl. Robinson's direction. The Pritchard video supported the officers' perceptions that Mr. Dziekanski was actively resisting them. The subject behaviour can be categorized as Active Resistant or Assaultive, depending on the perception of the individual officer. The Pritchard video indicates that Mr. Dziekanski kicked with his right leg, whether consciously or unconsciously.
- Cst. Millington's decision to use the weapon in push-stun mode under the circumstances described would represent a reasonable and appropriate use of force given the nature of the resistance. He

reasonably believed that the initial probes had not made sufficient contact. It would be reasonable to assume that one or both probes might become dislodged during the struggle, and the close quarters of the encounter precluded deployment of a second cartridge.

- Cst. Millington's targeting of the shoulder area in push-stun mode was consistent with training and was intended to create a window of opportunity for the other officers to gain control of Mr. Dziekanski's arms and apply handcuffs. He deployed the weapon twice in push-stun mode, and training advises officers that repeated push-stuns may be required to gain control of subjects. The audio track suggests that Mr. Dziekanski was continuing to actively resist after the first push-stun deployment.
- RCMP officers have been instructed in the Force Options Theory contained within the Incident Management/Intervention Model (IM/IM), which advocates that officers are not required to incrementally escalate through all categories of force options before they determine the appropriate use-of-force response. There are many circumstances, such as the incident in question, where it is reasonable and appropriate to escalate from Officer Presence to Intermediate Weapons without attempting Physical Control. The decision to escalate their force response option should be based upon preclusion — lower force options would be inappropriate and/or ineffective.
- If an officer discovers a weapon on a subject, the officer should assume that there is a second, as-yet-undiscovered one. In this incident, the officers were responding to a subject armed with a weapon, albeit one limited to close-quarters tactics. The officers responded with a conducted energy weapon, which allowed them to remain outside the effective range of the subject. Doing so was consistent with the One-Plus-One Theory.
- The officers and witnesses reported their perception that Mr. Dziekanski was about to or was assaulting the officers during the encounter. The officers had no reason to believe that their use of the conducted energy weapon would result in anything other than Mr. Dziekanski's temporary incapacitation. Sections 25, 27 and 37(1) of the *Criminal Code* appear to apply to the officers' actions in this incident.
- Reasonable grounds appear to exist for the officers to have arrested Mr. Dziekanski without warrant for mischief and/or causing a disturbance under the *Criminal Code*, as well as for drunkenness in a public place under the *Liquor Control and Licensing Act* or for mental disorder under the *Mental Health Act*.

- Tactical repositioning or disengagement is supported when there are reasonable grounds to believe that doing so may lead to a positive resolution of the incident. However, officers must be able to disengage safely. Here, the officers perceived that Mr. Dziekanski was going to assault them. It would have been impossible for them to outdistance the threat, given their proximity to Mr. Dziekanski. There was no reason to believe that disengagement would result in gaining voluntary compliance, or that police officers have a duty to disengage.
- The officers' follow-up care actions were reasonable and appropriate. They placed Mr. Dziekanski (apparently unconscious) in a semi-prone recovery position and their checks indicated that he had a pulse and respirations, which would preclude any more severe medical interventions by them, as they believed that medical professionals would arrive momentarily.

Sgt. Fawcett stated his conclusion as follows:

> The actions of the officers in this incident represent a reasonable escalation and de-escalation of force based upon the actions of the subject. The officers precluded lower force options, specifically high level Officer Presence in conjunction with Communications, by virtue of the fact that they had been attempted and failed. Once Officer Presence and Tactical Communications fail officers must necessarily escalate to the application of physical force. The officers used an Intermediate Weapon, specifically a conducted energy weapon, in conjunction with Physical Control to gain control of DZIEKANSKI. The officers' actions were consistent with their Common Law duties, various *Criminal Code* (Canada) provisions and RCMP policy and training....
>
> The reasonableness of a particular use of force must be judged from the perspective of a reasonable peace officer on the scene, rather than with 20/20 vision of hindsight.[199]

Sgt. Fawcett said that the National Use of Force Framework was developed as a national model, but individual police departments are not bound by it – they are free to develop their own model. The "wheel" is just a visual representation of the law and case law that has evolved over the centuries. It does not authorize the use of certain kinds of force in certain circumstances. It is the law that authorizes the use of force; the framework is merely a teaching aid, and gives guidance in terms of use-of-force decision-making.

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[199] Exhibit 89, p. 37.

He told me that when conducting a use-of-force analysis, he is required to measure the officer's subjective perception with the reasonableness of a reasonable police officer.

Sgt. Fawcett was asked why he described, as a minor discrepancy and easily understood, the perception of the officers that they were forced to wrestle Mr. Dziekanski to the ground, when the Pritchard video did not support this perception. He told me:

> A When a person's sympathetic nervous system is activated, if you formulate a plan – and again, I use the heading perception versus recall – it's an officer's perception of what is going on. If I intend to carry out a certain act and in the final outcome – for instance, I intend to tackle somebody to the ground – when I recall that event, I may recall the intended plan, not what actually happened. It's just a function of how we store memory, Mr. Commissioner.
>
> Q You didn't see the discrepancy as anything other than inadvertent? You just thought it was an inadvertent discrepancy, not intentional?
>
> A Absolutely, Mr. Commissioner. We at the Police Academy are routinely running recruits through simulations and taping them, and it is routine to have their version of events when we debrief them contradicted by the video in very similar manners, if you will.[200]

Sgt. Fawcett was asked whether he would have responded in the same way that the four officers did in this case. He replied, "I would think any group of officers, you'd have a range of responses depending again on their strengths and weaknesses, their success and failures in similar situations. Would I have done the same thing? Probably not."[201]

Sgt. Fawcett was asked, from viewing the Pritchard video, what caused Mr. Dziekanski's reaction to the weapon deployment:

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[200] Transcript, April 16, 2009, pp. 21-22.

[201] Transcript, April 16, 2009, p. 25.

Q	You saw a man drop to the floor, holding his chest, pushing himself around in a circle, screaming in pain, did you not?
A	In general terms, yes, Mr. Commissioner.
Q	All right. Well, did you ever think that his actions while he was on the floor and while the police were dealing with him had more to do with the pain that he was manifesting than it had to do with him resisting arrest?
A	I would – I can't assume anything, other than to say it could be both.[202]

Counsel for Cst. Bentley asked Sgt. Fawcett a series of hypothetical questions, based on a statement of assumed facts (Exhibit 92). He expressed the following opinions:

- The entry of the officers into the International Reception Lounge, Cst. Bentley's statements to Mr. Dziekanski ("Hi, how are you, sir? How's it going, bud?") and Cst. Millington's request for passport and identification were not at all unusual – typically you want to contain the scene first, to prevent the subject from escaping or escalating their behaviour or endangering anyone else.
- Given the broadcast information about an intoxicated male throwing things about, he would have expected the officers to maintain a reactionary gap of perhaps double the standard.
- He had no issue with the officers hopping over the handrail before entering the lounge. Their first tactic was to contain the problem, and having to circumnavigate the handrail would provide ample time for the subject to barricade himself, arm himself, or escape.
- You contain the area first, regardless of the type of call, and only then start interviewing potential witnesses.
- This was not the type of call for which he would have expected the officers to have developed a plan before arrival at the scene – responding to a call of an intoxicated male causing a disturbance is not an uncommon occurrence.
- Based on a viewing of the Pritchard video (3:41), Cst. Bentley appeared to be acting as a cover officer.
- After Mr. Dziekanski picked up the stapler (and Cst. Bentley perceived that Mr. Dziekanski was preparing to attack him or another officer, which constitutes combative behaviour under the IM/IM), it would be entirely consistent with training for Cst. Bentley to create distance and

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[202] Transcript, April 20, 2009, p. 76.

to deploy an intermediate weapon such as the baton – it adds length to the officer's reach, and encourages compliance through its implied use. It was certainly consistent with the One-Plus-One Theory. Section 37 of the *Criminal Code* does not require an assault to occur before steps may be taken to prevent one.

- It is not uncommon to have multiple officers trying to restrain a lone subject. In fact, recruits are trained in team control tactics for one officer to control the head, one officer to control the feet, and two officers to control each arm and hand, similar to what happened in this case.
- Cst. Bentley's conduct in this incident certainly appears to be consistent with training. He did nothing particularly glaring outside the IM/IM practice or standards, although Sgt. Fawcett would not advocate Cst. Bentley laying his baton on the ground before moving in to assist the other officers in restraining Mr. Dziekanski. Nothing in the assumed facts or video could be characterized as misconduct.
- Although the use of physical force (empty-hand control techniques) was an option, it is the force option most likely to result in injuries to officers and the subject. Officers are not required to attempt physical control before trying another force option. They merely have to preclude it as being inappropriate due to the circumstances as they perceive them.
- Use of pepper spray is not effective against 30 percent of subjects, especially those who are goal-oriented, suffering from a mental disorder, or intoxicated by drugs and/or alcohol. It also contaminates large areas and would likely have required shutting down a large portion of the Airport for decontamination.
- Use of a baton, which is essentially a steel club, can result in bruising, lacerations, or broken bones.
- A conducted energy weapon, has no contamination issues, allows the officer to stay at a distance (15-35 feet), has a significantly higher success rate than either batons or pepper spray, and is the least likely of any intermediate weapon to result in hospitalization.

Counsel for Cst. Rundel asked Sgt. Fawcett a series of hypothetical questions, based on a statement of assumed facts (Exhibit 94). He expressed the following opinions:

- Since Cst. Bentley and Cst. Millington engaged with Mr. Dziekanski, one would expect that Cst. Rundel would hold back and not engage directly, assuming the role of cover officer by stabilizing the scene, eliminating escape routes, preventing other people from unwittingly entering the scene, etc.

- Cst. Rundel tactically repositioned himself after Mr. Dziekanski picked up the stapler, according to training.
- He could see how Cst. Rundel could have perceived that Mr. Dziekanski was combative.
- Cst. Rundel acted as a cover officer and then transitioned into a control officer when he assisted the other officers in restraining Mr. Dziekanski. His actions were consistent with RCMP training, and he acted in a correct manner. Sgt. Fawcett's only criticism would be that he would have preferred to see the officers move in sooner and try to gain physical control while Mr. Dziekanski was still under current.

Counsel for Cst. Millington asked Sgt. Fawcett a series of hypothetical questions, based on a statement of assumed facts (Exhibit 93). He expressed the following opinions:

- Cst. Millington's request for passport and identification, and his hand gestures, appeared reasonable in terms of attempting to calm the situation and reduce tension.
- Even though Mr. Dziekanski's behaviours would be classified as assaultive, that does not necessarily mean that the officer can justify use of that level of force option. Any use of force is based on the concept of preclusion, that the officer precluded lower levels of force as being inappropriate and/or ineffective – the officer tried them and they did not work, or an urgent need to control the situation rendered lower levels of force inappropriate. Conversely, the officer has to preclude higher levels of force as not being justified or appropriate, given the circumstances. In this case, the situation did not warrant use of a conducted energy weapon in the first instance, and Cst. Millington attempted use of lesser force options.
- When Mr. Dziekanski threw up his hands and turned away from the officers, he displayed resistant behaviour.
- When Mr. Dziekanski picked up the stapler, held it in his right hand with his fist clenched around it, and started advancing toward the officers, he displayed combative behaviour. Assuming that Cst. Millington perceived this as a threat to the officers, his deployment of the weapon was consistent with training.
- Because of auditory exclusion during periods of stress, it is not surprising that Cst. Millington did not hear Cpl. Robinson's first command to deploy the weapon.

- Mr. Dziekanski's reaction to the first deployment is consistent with the weapon making only intermittent contact.
- Where the officer believes that the subject is getting only partial effect of the current, it is reasonable to cycle it a second time in probe mode, either by depressing the trigger again or by inserting a new cartridge and firing a second set of probes. Which option is chosen will depend on the officer's training and comfort level with reloads under stress.
- It appears that there was better, more consistent contact during the second deployment; Mr. Dziekanski's turtling-up actions are common when probes hit the torso area.
- The three or four sets of burn marks on Mr. Dziekanski's left shoulder area are consistent with deployment of the weapon in push-stun mode. The fact that they are very close together is consistent with them all being part of a single dynamic application, not separate deployments.
- The fact that Cst. Millington has no recollection of deploying the weapon twice in push-stun mode is not surprising – commonly an officer will not recall an event that occurred during a stressful period.
- When Cst. Millington decided that the third deployment in probe mode was not effective, it would have been more effective for him to leave the cartridge in place before using the weapon in push-stun mode, because the electrical current may have gone between the probe that was properly seated and the point of contact in the push-stun. This might have caused some motor dysfunction, rather than only pain compliance when the weapon is used in push-stun mode with the cartridge removed.
- Assuming that Cst. Millington did not believe that a lesser force option would have been effective on Mr. Dziekanski, and that use of the conducted energy weapon was the best force option, his actions would be consistent with the training that exists in the province of British Columbia.
- With respect to multiple deployments, the officer has to make a reasonable assessment for each deployment and have a reason why he or she thinks it might be necessary, given the totality of the circumstances the officer is confronted with, to deploy again.

Counsel for Cpl. Robinson asked Sgt. Fawcett a series of hypothetical questions, based on a statement of assumed facts (Exhibit 95). He expressed the following opinions:

- It was appropriate for the more junior officers to have initial contact with Mr. Dziekanski so that Cpl. Robinson, as the senior officer on scene, would have the widest view of what was going on.
- The fact that the initial report of thrown luggage and broken glass was not visible on the officers' arrival should not have any impact on their response. Their first goal was to contain, and then they could set out to investigate where those events allegedly occurred.
- Superior strength through numbers is part of physical control. It is hoped that the subject will perceive insuperable odds and decide that it is best to comply with the officers.
- The officers' initial approach, with hands down, was if anything, too casual. It would be preferable to have their hands at chest level, to enhance reaction time.
- He would not have allowed Mr. Dziekanski to go into his luggage. Recruits are taught, when asking for identification, to ask where it is first — they can obtain the identification themselves rather than have the subject access it.
- Cpl. Robinson's order ("No, stop") to stop Mr. Dziekanski from going into his luggage, and making a hand gesture to calm down, was consistent with training.
- If Cpl. Robinson's intention in directing Mr. Dziekanski to place his hands on the counter was to keep his hands in plain view, that was perfectly reasonable, although from a tactical perspective, it might not be the preferred option unless Cpl. Robinson had scanned the counter to ensure there was nothing there that might be used against the officers.
- Cpl. Robinson acted appropriately in drawing his baton when he did.
- It was not necessarily wrong for Cpl. Robinson to order Cst. Millington to deploy the conducted energy weapon, although it is up to the officer deploying the force option to conclude whether or not the option is appropriate, given the circumstances.
- Deployment of the conducted energy weapon certainly fell within the spectrum of force options that would have been appropriate, given the behaviour that the officers perceived. Cpl. Robinson's perceptions were reasonable, and his preference for deployment of the conducted energy weapon rather than the baton was reasonable.
- After the first deployment, there may have been an opportunity to step in and deliver a thrust kick to unbalance Mr. Dziekanski and knock him to the ground, but he would not want an officer to approach

Mr. Dziekanski from the side on which he was brandishing the stapler. Those responses, and deploying the conducted energy weapon, were tactical options that the officer might consider.

- If Cpl. Robinson placed his knee across Mr. Dziekanski's shoulder blades, to prevent him from pushing up and getting up off the ground, that was entirely consistent with training.
- Assuming that Cpl. Robinson heard Mr. Dziekanski make snoring sounds and became aware that he was unconscious, placing him on his side in the semi-prone recovery position was entirely consistent with training.
- Assuming that Cpl. Robinson monitored Mr. Dziekanski's breathing and pulse, was aware that paramedics were responding Code 3, and stayed with Mr. Dziekanski until their arrival, that would be consistent with training.
- He had no difficulty with Cpl. Robinson's reluctance to remove the handcuffs for the firefighters and paramedics because of the risk that Mr. Dziekanski might regain consciousness and become violent. He has seen that happen many times.
- It was appropriate for the officers to wear leather gloves, given the dispatch information about broken glass.

b. Corporal Gregg Gillis

Corporal **Gregg Gillis**, who has been an RCMP officer since 1990, is currently the Regional Use of Force Coordinator. In 2007 he was the officer in charge of use-of-force training for the Richmond detachment. In that capacity, he trained Constables Bentley, Rundel, and Millington in July and August 2007 in the use of conducted energy weapons. I qualified him as an expert on the use of force and conducted energy weapons by RCMP officers, and on training in the use of force and conducted energy weapons.

He told me that the training program consists of two eight-hour training days, including scenario-based training sessions and a standardized examination with an 80 percent score required in order to be certified as a conducted energy weapon operator. All three officers passed the training course and were certified for three years.

In 2007, RCMP officers were trained that they were entitled to deploy a conducted energy weapon when a subject was demonstrating active resistance or behaviour greater than active resistance, taking all relevant situational factors into account. He told me that training does not require the officer to specifically eliminate other options before moving to the conducted energy weapon. Their choice is based on their assessment of risk and the totality of the circumstances. He added:

> Q Is it a general principle of use of force that would have been incorporated into the TASER training course that officers should use the least amount of force necessary to resolve a situation, taking into account the situational factors and their assessment at the scene?
>
> A Well, that's always a professional goal is to try and resolve any given situation with a minimal amount of force. But it's – so the officers are told that that's a professional goal that they should strive for. But we accept in dynamic situations that that isn't – especially when they unfold quickly, that isn't always the case.
>
> Q Okay.
>
> A But that's part of their assessment phase when they're looking at all those situational factors and assessing risk, is there something I can do here to establish control that is lesser than other options, and also keeping in mind the potential risks to the officers, the general public, the people they're dealing with. All that has to be taken into account as the situation's unfolding.
>
> Q Is that a fair summary of one of the messages that would have been incorporated into your TASER training courses in 2007?
>
> A Yes, consistent with the training on the IM/IM.[203]

Cpl. Gillis told me that training included possible multiple deployments of the weapon. Officers were taught to, wherever possible, assess risk and assess whether or not the device was still required to be used, and/or assess the possible need to transition to another option.

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[203] Transcript, April 23, 2009, p. 14.

Officers were taught, whenever tactically appropriate, to give a verbal challenge, but they were not taught to display the weapon or spark it in the hope of gaining compliance without discharging it. The RCMP protocol is that the weapon stays holstered until the officer determines that it is appropriate to potentially use it, in which case the officer draws it and, if appropriate, issues the verbal challenge before deployment.

Officers are trained that if a conducted energy weapon is deployed in probe mode and both probes make contact, the subject will fall to the ground and will remain immobilized during the five-second cycle, but as soon as the cycle ends the subject can immediately stand back up and continue their previous behaviour. If the subject does not immediately fall to the ground, officers are trained that it is due to a weapon malfunction (in which case there is no electrical flow) or to an interruption in the electrical flow because of an air gap, such as where one of the probes is attached to clothing that flaps against and away from the subject's skin.

A clacking sound indicates that the weapon is either not effective or only partially effective. Hearing that sound is a critical piece of information telling the officer that the weapon may not be effective, which should be incorporated into their assessment of the risk.

When a conducted energy weapon is used in push-stun mode, it is primarily used for pain compliance, although it does cause some degree of localized motor dysfunction in the area where it is deployed, which may, for example, cause the subject to release something.

Officers are taught to communicate respecting deployment of the weapon. The perfect or best outcome is for the backup officers to move in as soon as the subject is immobilized and apply handcuffs. It is always advisable for the officer with the weapon to advise the other officers when he or she is about to deploy it.

The conducted energy weapon is an intermediate device according to the Incident Management/Intervention Model (IM/IM), and it may be deployed in probe or push-stun mode for the same level of subject behaviour. On a subsequent internal review, the officer must be able to explain why the weapon was used, in whichever mode they chose to use.

Officers are taught that they are required to complete a Form 3996 CEW Usage Report after deployment of a conducted energy weapon. As with any report, an officer is expected to complete it with the greatest degree of accuracy possible from his or her recall.

Cpl. Gillis told me that the only way that a conducted energy weapon could discharge continuously for more than five seconds would be if the officer held the trigger down for the full period. Officers are trained that the standard method of deployment is to pull the trigger and then release it, in which case it will run for the five-second cycle. It would be a marked departure from the norm to hold the trigger down for six seconds, and the officer would need to articulate why that was required.

Officers are trained that the multiple application of any use of force increases risk. That principle applies to conducted energy weapons as well. For example, when a subject falls to the ground when incapacitated, there is a risk of injury from the fall. Similarly, a five-second deployment causes muscles to contract, which may cause strained muscles or ligaments, or even stress fractures, and multiple deployments increase the risk of those types of injuries. However, officers are taught that "there's no medical information that is available that supports that it's a cause of death or that it has a direct relationship on core body functions such as cardiac care or respiration, [or] that increased exposure does carry increased risk."[204]

Cpl. Gillis told me that most people who are subjected to a conducted energy weapon discharge find it extremely painful, and pain is always one of the considerations in the officer's assessment of risk and trying to decide what option or tool he or she should use to manage that risk.

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204 Transcript, April 23, 2009, p. 30.

Officers are trained about less-lethal weapons systems. It should be an officer's operational goal, when taking a person into custody, "to try and choose options or tools that provide for less potential for causing serious injury or the death of the people that you're dealing with. That's always the goal."[205] Cpl. Gillis gave me an example: there is less potential for injury in using a conducted energy weapon on a subject than there would be in striking the subject with a defensive baton or resorting to the more conventional tactics of grabbing the subject, fighting him or her to the ground, and having a lengthy physical altercation.

Cpl. Gillis told me that when a subject's arms are not available, but the back area is, the preferred area to deploy the weapon in push-stun mode is in the scapula or upper shoulder area. It is an effective area for a degree of motor dysfunction, for getting the arm behind the back, for reducing the risk of contacting the facial area, and for staying away from the kidneys.

In response to a question about whether there was time to give Mr. Dziekanski a warning before deploying the conducted energy weapon, Cpl. Gillis said:

> In relation to the time frame for them to issue a challenge, what I observed on the limited view that I had on the tape, Mr. Commissioner, is that the event unfolded quite rapidly. The opinions that I offered yesterday were also based on one other critical piece of information, and that's that Mr. Dziekanski advanced towards the officer. The advancement or closing distance on the officer at that point would require the officer to reasonably consider the use of the device at that point.[206]

Cpl. Gillis agreed that in 2007 recruit and in-service use-of-force training included de-escalation techniques and verbal crisis-intervention matters. The RCMP has a subject matter expert in relation to mental health crisis intervention training, and mental health experts are brought in to assist officers with understanding persons who are in mental health or emotional crisis and learning how to defuse those situations using non-traditional police tactics.

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[205] Transcript, April 23, 2009, p. 64.

[206] Transcript, May 12, 2009, p. 35.

Counsel for Cst. Millington asked Cpl. Gillis a series of hypothetical questions, based on a statement of assumed facts (Exhibit 93). He expressed the following opinions:

- Cst. Millington was gathering more information and updating his risk assessment as he moved through the public Meeting Area.
- It was appropriate for him to climb over the handrailing rather than walk around it, as this gave him a direct line of approach and allowed him to maintain observation.
- Cst. Millington's observations that Mr. Dziekanski was pacing back and forth, was sweaty, appeared to be under the influence of something, was breathing heavily, and had his eyes really wide open were all indicators of a person who was in a highly aroused or agitated state.
- When officers are faced with a rapidly unfolding event, where there is a risk to public safety or to property, the first priority is to re-establish a degree of control or calm, and then revert to investigation, such as interviewing witnesses.
- With four officers present, it was completely reasonable for three officers to approach Mr. Dziekanski and for the fourth (Cpl. Robinson) to hold back.
- Cst. Millington's initial request for passport and identification, and his hand gestures, were reasonable efforts to engage Mr. Dziekanski, in order to assess his degree of compliance in relation to de-escalating and establishing a degree of control.
- When Mr. Dziekanski threw up his hands and moved away from the officers (thereby breaking contact with them), Cst. Millington reasonably assessed that behaviour as a degree of resistance in relation to the officer's attempt to control the event.
- When Mr. Dziekanski moved to the nearby desk, knocked some items off the desk, picked up the stapler, held it and his other hand in a clenched fist at chest level, and started advancing toward the officers, his behaviours could reasonably be categorized as combative under the IM/IM, and use of the conducted energy weapon would be completely appropriate, preferably in probe mode.
- Based on Mr. Fredericks' evidence that Mr. Dziekanski took three distinctive steps toward the officers, Mr. Dziekanski was "more able to deliver any potential attack or any potential strikes upon the officers,"[207] in which case deployment of the conducted energy weapon was appropriate.

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[207] Transcript, May 11, 2009, p. 65.

- It is reasonable that Cst. Millington did not hear Cpl. Robinson's initial command to deploy the weapon. In any event, he did not require Cpl. Robinson's approval, and he is held accountable for his use of the weapon.
- From the Pritchard video it does not appear that Mr. Dziekanski was getting the full effects of the electricity during the first five-second cycle. He was experiencing pain stimulus and a degree of loss of motor control.
- Based on Cst. Millington's perception that the first deployment was not fully effective (because he had not fallen to the ground), a second deployment would be consistent with training. Even though Mr. Dziekanski may have actually fallen to the floor before the termination of the first deployment, Cst. Millington could have perceived him as still standing.
- It does not appear that the second deployment was fully effective, which is not surprising if the first deployment had not been fully effective either.
- It is quite reasonable for an officer to deploy the weapon in push-stun mode against the shoulder area, if he perceived that the subject was actively resisting the officers' attempts to get his arms behind his back in order to handcuff him.
- Cst. Millington responded consistent with his training and with an industry standard. There was nothing that he did wrong in this incident.
- With respect to the suggestion that four officers could have wrestled Mr. Dziekanski to the ground:

  > The training now is that officers should try to avoid going into close contact and instead should try and use devices or tools, OC spray, or the CEW in this case would be consistent.... The goal is to use that at distance, because it allows for better assessment and it helps minimize the risk of injury to all the parties involved, including the person you're restraining.[208]

- He had reviewed the expert report of Mr. Orville Nickel, a former RCMP officer who had retired from the RCMP before the IM/IM came into force and before conducted energy weapons were introduced into use. He was asked to comment on several of Mr. Nickel's opinions, and told me that he disagreed with them.
- There is a professional expectation that an officer will be empathetic to the situation that a subject finds himself in, but that does not preclude

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[208] Transcript, May 11, 2009, p. 74.

> the officer's duty to act, to resolve the situation, or to establish a degree of control to that event.

Counsel for Cst. Bentley asked Cpl. Gillis a series of hypothetical questions, based on a statement of assumed facts (Exhibit 92). He expressed the following opinions:

- When Cst. Bentley approached Mr. Dziekanski and said, "Hi, how are you, sir? How's it going, bud?" that was completely appropriate social language to establish his presence and to engage Mr. Dziekanski.
- When Cst. Bentley saw Mr. Dziekanski pick up the stapler and swing it out in front of the officer, and thought that an officer was going to be hit with the stapler, it was appropriate for him to tactically reposition himself back and to the side, having perceived a degree of risk.
- Cst. Bentley's actions in withdrawing and extending his baton were in accordance with his training and with the IM/IM standards, because he perceived Mr. Dziekanski to be combative.
- It was appropriate for Cst. Bentley to move in and assist the other officers with the arrest and control.
- Overall, Cst. Bentley's actions were consistent with his training and with the escalation and de-escalation of the event.

Counsel for Cpl. Robinson asked Cpl. Gillis a series of hypothetical questions, based on a statement of assumed facts (Exhibit 95). He expressed the following opinions:

- From the perspective of Mr. Dziekanski, seeing the four officers jump over the handrailing may have made him fearful, causing him to become more violent. Or it could have had the opposite effect, causing Mr. Dziekanski to de-escalate his behaviours.
- It was appropriate for Cpl. Robinson, as the officer in charge, to hold back and let the three constables resolve the situation. He could assess his officers' actions and step in and take action if necessary.
- When Mr. Dziekanski reached down toward his luggage, it was appropriate for Cpl. Robinson to prevent him from doing so, because the officer did not know what was in the luggage.
- When Cpl. Robinson held out his hand and indicated for Mr. Dziekanski to put his hands on the counter, he was having Mr. Dziekanski create some distance from the luggage. By moving toward the counter, Mr. Dziekanski was complying, and the situation was de-escalating.
- Cpl. Robinson's actions were consistent with the IM/IM, and were the actions he would expect of a similarly trained officer.

- Mr. Dziekanski's clenching of his left fist, in addition to the right fist holding the stapler, were threat cues implying that he was getting prepared to become combative. Moving toward Cpl. Robinson would lead reasonably to an increased perception of risk.
- It was reasonable for Cpl. Robinson to direct Cst. Millington to deploy the weapon again, having concluded that the first deployment had not been effective.
- It was consistent with RCMP training for Cpl. Robinson and the other officers to control Mr. Dziekanski by handcuffing him.
- Officers are trained that their knee or shin area should end up across the subject's back, over top of the shoulder, pressing down on the upper back area and around the shoulder blade area, to try to control the subject and keep him on the ground. If their leg or knee is in the subject's head or neck area, they should continue to get the handcuffs applied before getting off the subject.
- It was appropriate to place Mr. Dziekanski in the recovery position after he was restrained, especially when there was an indication of laboured breathing.
- It was appropriate to monitor Mr. Dziekanski's breathing and pulse, and to stay with him until medical responders arrived.
- It was reasonable for Cpl. Robinson to be reluctant to remove the handcuffs for the medical responders and to advise them of the force used in restraining Mr. Dziekanski.

Counsel for Cst. Rundel asked Cpl. Gillis a series of hypothetical questions, based on a statement of assumed facts (Exhibit 94). He expressed the following opinions:

- When Mr. Dziekanski picked up the stapler, it was reasonable for Cst. Rundel to characterize his behaviour as combative.
- Cst. Rundel acted professionally and in accordance with his training in assisting the other officers in handcuffing Mr. Dziekanski.

c. *Orville Nickel*

Mr. **Orville Nickel** joined the RCMP in 1969 and retired in 1995 as a sergeant in the Commercial Crime Section. Between 2003 and 2006 he did contract work for the RCMP in its Integrated Market Enforcement Team. During his career, Mr. Nickel trained recruits in the use of force at the Regina Depot for three years, and subsequently was a local firearms instructor and use-of-force trainer at the Burnaby detachment. He completed a one-day TASER conducted energy weapon refresher course in 2005. He has been accepted as an expert witness in the use of force by several British Columbia courts. Although Mr. Nickel retired before the RCMP introduced conducted energy weapons or adopted the IM/IM, I accepted him as an expert in the use of force generally. I was satisfied that ultimately the use of force must be consistent with the criminal law, which has not changed recently. How his general expertise relates to the specifics of what occurred in this case may affect the weight that I attach to his opinions.

Mr. Nickel told me that one of the major officer/subject factor considerations in the use of force is the ratio of officers to subjects that in this case was four officers to one subject.

One of the tactics of dealing with difficult situations is to change the pace at which events are occurring. One of the alternatives that might have been useful in this case would have been for the officers to pause before confronting Mr. Dziekanski and to formulate a plan or strategy. There is no evidence from the video that either the officers or members of the public were immediately in danger. For example, two of the officers could have maintained contact with Mr. Dziekanski, while the other two officers could have talked to civilian witnesses and Customs and Immigration officers to obtain background information about what had gone on before their arrival. This could have bought some time and slowed things down, creating the opportunity for Mr. Dziekanski to settle down. He said:

> What did the police officers have to fear by spending some time in observing and trying to calm the circumstances rather than getting into escalating in levels of force.[209]

Mr. Nickel told me that it is clear that the supervising corporal quickly took command upon entering the scene, in giving commands to Mr. Dziekanski and in commanding Cst. Millington twice to deploy the conducted energy weapon. Given the limited experience of the three constables, they should have been looking to the corporal for direction in how to deal with the situation. When asked for his opinion as to the appropriateness of the degree of force employed by the officers, Mr. Nickel said:

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[209] Transcript, May 22, 2009, p. 46.

> Any time that there are alternatives that exist of lesser levels of force, those lesser levels have to be examined and employed if at all possible. I mean, with four police officers versus one subject, you know, it could have been – in terms of arresting Mr. Dziekanski, it could have been as simple as one officer for each limb and just carrying him away if they needed to do that. That may not have been necessary to go to a level of using a weapon in order to subdue Mr. Dziekanski under those conditions.[210]

Mr. Nickel said that he did not see the reason for the second through fifth deployments of the conducted energy weapon. Mr. Dziekanski fell to the floor during the first deployment, and when he went into the fetal or turtling position with his arms against his chest and his knees up toward his waist, this was likely in response to the extreme pain. Applying more pain in such circumstances may strengthen that position or cause the subject to be even more determined to stay in that position because it is a position of comfort in a time of pain.

With respect to handcuffing Mr. Dziekanski, the video shows that two officers had the handcuffs in one hand, while using the other hand to try to pry Mr. Dziekanski's arm around behind his back. It would have been more effective to leave the handcuffs on their belts, use both hands until they had got his arm behind his back, and then bring the handcuffs out and apply them.

Mr. Nickel told me that the manner in which Cst. Bentley collapsed his extendable baton was not professional. It should have been done away from the subject and outside of public view, and the preferable way to collapse the baton is to hold it between the thumb and forefinger and lightly drop it on the concrete floor. Grabbing the baton with a fist and driving it into the floor locks the baton more firmly in its locked-out position.

Mr. Nickel said that it is preferable for one officer to make contact with the subject and for the other officers to step back to observe and assist where required. This enhances consistency of message. When more than one officer gets involved, it starts to create a sense of confusion, even when there is no language barrier.

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[210] Transcript, May 22, 2009, p. 47.

Mr. Nickel expressed the view that the deployment of the conducted energy weapon (or any kind of weapon or even empty-hand physical force) occurred very early in this encounter. He said:

> I would have liked to have seen it evolve differently and different levels of force applied, or at least some time taken to consider the different levels.... And I mean, it's more appropriate and you don't lose anything by waiting and allowing some time to pass, to try to get – allow the circumstances to settle themselves down before jumping in to apply physical force.
>
> I didn't see in any of the evidence that I reviewed that there was a need to rush through this particular circumstance.[211]

Mr. Nickel said that when an officer applies pain compliance techniques, there is a rational component. The officer should be communicating to the subject what the officer's expectations are and what the subject needs to do in order to mitigate the pain. However, when dealing with subjects who have emotional or mental health difficulties, "the best strategy is to try to avoid physical confrontation altogether if that's possible, because the rational components of that confrontation are going to be missing."[212]

Mr. Nickel agreed that once the decision has been made to apply physical force, the officers should move in and restrain the subject as quickly as possible.

Mr. Nickel was asked whether Mr. Dziekanski's throwing up his hands and moving away from the officers was resistive behaviour. He responded that it might have been like shrugging shoulders and saying, "Well, what is it that you expect from me? You know, you're asking me to get my identification and now all of a sudden you're saying I can't go in my luggage where my identification is located." It has the potential for creating a circumstance of confusion within the mind of the subject, when more than one officer tries to communicate with him at one time.

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[211] Transcript, May 22, 2009, p. 58.
[212] Transcript, May 22, 2009, p. 60.

Mr. Nickel told me that Mr. Dziekanski's picking up of the stapler and holding it in a clenched fist was not combative behaviour itself, although it was indicative that combative behaviour might be happening very soon. In his view, Mr. Dziekanski would be much more dangerous with two empty hands than he would be with a stapler in his hand, because the stapler limits what he can do with that hand and the officer knows what to expect.

When the officer is not able to communicate with the subject, and relies on a conducted energy weapon to achieve pain compliance, Mr. Nickel said that there is a risk that the officer will misinterpret the subject's reaction as resistance, when in fact the subject just does not know what is expected of him – the more the weapon is used, the more the subject resists, and the more the subject resists, the more the weapon is used. Where does the cycle stop?

Several weeks after Mr. Nickel testified, Sgt. Fawcett prepared a detailed written rebuttal (Exhibit 187), to which I have given careful consideration.

d. Dr. Michael Charles Webster

Dr. **Michael Charles Webster** has a B.A. degree from the University of Notre Dame, an M.Ed. degree in counselling/clinical psychology from Western Washington State College, and an Ed.D. in counselling/clinical psychology from the University of British Columbia, and is a Registered Psychologist. He has acted as a psychological consultant to the FBI and to the RCMP. He has been involved in crisis negotiations around barricaded persons, hostage takings, and kidnappings, both domestic and foreign. He has taught crisis intervention and crisis negotiation courses at the Canadian Police College and the Justice Institute's Police Academy. I accepted him as an expert in the use of force from a crisis intervention perspective.

Dr. Webster told me that he disagreed with the suggestion that responding to this dispatch did not require a plan. The officers have said that this was an unusual call, and according to the RCMP's CAPRA model, the most experienced officer should have taken charge. It is integral to the IM/IM to continually assess the risk and to formulate a plan that will assist the officer to act. In this case the supervising corporal, after identifying the subject of the dispatch ("locate"), should have dispatched one of the constables to the Customs Hall to prevent arriving passengers from entering the International Reception Lounge ("isolate"), instructed another officer to evacuate members of the public from the area ("evacuate"), and then initiated interaction with Mr. Dziekanski ("communicate"). There was no rush, and he could begin to interact with a very distraught, hyper-aroused individual.

Dr. Webster said that during recruit training at RCMP Depot, there are approximately 200 classroom sessions over the six-month period of training, amounting to 365-370 classroom hours. About 60 of those hours are devoted to conflict avoidance, conflict resolution, and crisis intervention. Recruits are taught that it is much easier to enter a situation with a low intensity and then increase the intensity if necessary, than to go in at a high level of intensity – it is next to impossible to go in at an intensity of eight or nine on a scale of ten, and then expect to defuse an emotionally distraught individual. A man in Mr. Dziekanski's state of hyper-arousal would have had his cognitive processes disrupted and disorganized. He would not be able to comprehend instructions, use good judgement, or make good decisions. The objective should have been to help him regain his cognitive organization. In this case the officers initially did this by modelling calmness, and Mr. Dziekanski responded appropriately. He was happy to see them and his hands went down to his side. But then the officers gave him several sets of instructions; he could not cope with one set, let alone three.

Recruits are taught to approach a situation using neutral, non-threatening body postures and calm, non-confrontational tones. Vaulting over the handrail was inconsistent with this approach. However, Cst. Bentley's initial verbal communication with Mr. Dziekanski was effective in calming him down, because Mr. Dziekanski dropped his hands to his side. But everything the officers did after that was inconsistent with their conflict resolution training.

It is important for officers to be empathetic, to put themselves in the subject's shoes. When the four officers formed a semicircle around Mr. Dziekanski and placed their hands near their weapons, this was absolutely inconsistent with getting him to calm down. In his state of hyper-arousal, this action was bound to stimulate reactive behaviour. The officers failed to realize that they were dealing with an emotional crisis (where an individual has lost his mental balance and his usual coping mechanisms, and is unable to deal with the present situation), rather than a behavioural emergency (where an individual is a threat to himself or another person). In a behavioural emergency tight containment is required, but in an emotional crisis it is not. Circling him only increases his fear.

Dr. Webster told me that the tactical considerations during this incident (e.g., containment, position, backup, police tools available, subject's condition, subject's weapon) were significantly in favour of the officers. Applying the One-Plus-One Theory, if Mr. Dziekanski's resistance was at level 2, then officers are taught to go in at level 3 in order to bring the subject under control. This would be a proportionate application of force. However, deploying the conducted energy weapon was going in at level 9, which was a "precise" application of force, designed to overwhelm, dominate, or destroy. It was not necessary. He added:

> What we've just talked about in terms of tactical considerations and the difference between precise and proportionate force, arguably makes the second, third, fourth and fifth cycles of the TASER an excessive use of force.[213]

Dr. Webster said that he is one of the service providers in the RCMP's Members' Employee Assistance program, in which he conducts critical incident debriefings. He told me that the RCMP approach is based on the Mitchell model:

> It begins with an introductory phase and then there is a fact-finding phase where the members sit and they relate to details of the incident that they've just been involved in. Everyone goes around the table and they relate the details of the incident. Then there's a thought phase where we talk about what our thoughts were in regards to what happened. Then there's an emotional phase where we talk about our feelings in regards to what has happened. And then, after that, usually the other – the final – there's an

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[213] Transcript, May 12, 2009, p. 72.

> educational phase and then the person who's running the group takes over, deals with the questions and wraps it up and off we go.[214]

It was suggested to Dr. Webster that the situation escalated, from the police perspective, in a fraction of a second, from dealing with an unarmed individual to someone who was armed. He responded that Mr. Dziekanski was not behaving in a vacuum:

> It was an interaction with the policemen and everything they were doing was inconsistent with what you have just described to me in the first few moments of their meeting where they were able to get him to keep his hands at his side. After that, it began to degenerate, and it degenerated because of what they were doing. He was responding to what they were doing, they were responding to what he was doing and now we're in a never-ending dance here that ends up in tragedy.[215]

Dr. Webster cautioned against reading too much into the term "hyper-arousal." He could not give a clear diagnosis of Mr. Dziekanski's mental condition from viewing the Pritchard video. Mr. Dziekanski may have been in a hyper-aroused state, but the most one can really say for sure is that Mr. Dziekanski was "not quite himself." Dr. Webster emphasized that while police perception is their reality (e.g., in their mind the stapler was a credible threat), there was a piece missing. They also had to take into account tactical considerations, which in this case would have reduced the credibility of the stapler as a weapon.

Several weeks after Dr. Webster testified, Sgt. Fawcett prepared a detailed written rebuttal (Exhibit 187), to which I have given careful consideration.

F. FINDINGS OF FACT AND CONCLUSIONS

Before making any findings of fact or reaching any conclusions, I gave careful consideration to the written and oral closing submissions of counsel for the participants.

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[214] Transcript, May 12, 2009, p. 76.

[215] Transcript, May 12, 2009, p. 93.

1. Responding to calls for assistance

At about 1:26 a.m. on October 14, 2007, Corporal Robinson and Constables Rundel, Bentley, and Millington were sitting together during a lunch break at the Airport sub-detachment when they received a call from Richmond Dispatch. Dispatch informed them that there was an intoxicated 55-year-old non-white male at the International Arrivals Reception Lounge throwing luggage around. He had dark hair and a white coat. Cst. Millington was the first officer to respond to the call, so it was assigned to him. The other two constables went as well, and Cpl. Robinson decided to go in order to oversee and to supervise. The officers testified that there was no discussion among them when the call came in, and that there was no instruction or assignment about who was to attend.

Each officer drove to the International Terminal separately, without lights or sirens. En route, they were updated by radio that the male was now throwing chairs through glass windows in the same area. The officers testified that there were no discussions en route about the dispatch, and that there was no plan in place as to how to deal with this incident. Several officers told me that it was hard to plan for this type of call – it would be better to get to the scene and make an assessment there, before developing a plan.

It took about one minute to reach the International Terminal. All four police vehicles arrived and all four officers entered the building at about the same time. The officers testified that they did not have any conversation among themselves as they entered the building.

While walking through the public Meeting Area, Cst. Millington heard some yelling, but did not understand it and did not know where it was coming from. I expect that what Cst. Millington heard was Mr. Dziekanski calling out, "Police. Police" when he first saw the officers approaching, which was captured on the Pritchard video. At that time, Mr. Dziekanski was standing just inside the swinging glass doors, with two wheeled chairs blocking the walkway.

Cst. Bentley heard a female employee of Horizon Air say in an excited, very high, fast voice, "He's over by the glass," pointing to where Mr. Dziekanski was. She also said that he was breaking glass or trying to break glass. Cst. Rundel, Cst. Millington, and Cpl. Robinson heard varying combinations of "He doesn't speak English" or "He speaks Russian." Cpl. Robinson heard an Airport security person say words to the effect, "He's freaking out." Cst. Bentley turned to the other officers and asked whether anyone had a TASER, and Cst. Millington said, "Yes."

In addition to the evidence of the four officers, I heard evidence about Chief Superintendent Bent's November 5, 2007, e-mail to Assistant Commissioner Macintyre, in which he stated that Superintendent Rideout had indicated to him that the four officers had discussed the response en route to the Airport and decided that if Mr. Dziekanski did not comply they would use a conducted energy weapon against him. Despite the RCMP's disclosure (after this e-mail came to light) of 18,000 documents relating to the Dziekanski incident and the resulting criminal investigation, there is almost no other documentary evidence that sheds light on what led up to the drafting of this e-mail or what happened as a result of it.

From this evidence, I have drawn several conclusions. First, there is conflicting evidence respecting whether the four officers developed a plan en route to the Airport to deploy the conducted energy weapon if Mr. Dziekanski did not comply. On the one hand, I have the sworn evidence of the four officers that they had no such discussions. I have evidence from several witnesses that this was not the type of dispatch that would call for development of a plan. In my view, it is entirely plausible that the officers would want to wait until they got to the Airport before they made a risk assessment and formulated a plan. Supt. Rideout, the officer in charge of the IHIT investigation, told me that IHIT found absolutely no evidence to indicate that the four officers made any plan en route to the Airport. Finally, there is evidence that as Cst. Bentley approached the handrail, he turned his head and directed a general question at the other officers as to whether anyone had a conducted energy weapon – an illogical gesture if they had already developed a plan to use such a weapon.

On the other hand, there are several facts that are consistent with development of a plan. It was only 26 seconds between the time that Cst. Bentley first spoke to Mr. Dziekanski and the time when Cst. Millington first deployed the conducted energy weapon – a surprisingly short period of time to make initial contact, establish communication, make a risk assessment, conclude that force was necessary, and conclude that no lesser force option was appropriate. In addition, we have the Bent e-mail. On its face, the e-mail is unequivocal: "Finally, spoke to Wayne and he indicated that the members did not articulate that they saw the symptoms of excited delirium, but instead had discussed the response en route and decided that if he did not comply that they would go to CEW." In his direct examination, Chief Superintendent Bent said that the e-mail accurately reflected his conversation with Supt. Rideout. However, in cross-examination he acknowledged that he certainly could have misunderstood parts of what Supt. Rideout said about the officers developing a plan en route to the Airport. Supt. Rideout testified that the first two paragraphs of the e-mail accurately reflect their discussion, but the way Chief Superintendent Bent portrayed his comments in the third paragraph was wrong.

I am satisfied that Chief Superintendent Bent and Supt. Rideout had some conversation about the four officers' version of events, which likely included discussion of the prompt deployment of the conducted energy weapon – that was what Chief Superintendent Bent had earlier that morning asked Chief Superintendent McGowan to find out about, which presumably led to the Bent/Rideout conversation. The contents of Chief Superintendent Bent's third paragraph could not have come out of thin air. However, we do not know the substance of the Bent/Rideout conversation on this matter, and we are left with Supt. Rideout's unequivocal assertion that Chief Superintendent Bent's account is wrong, and Chief Superintendent Bent's candid acknowledgement that he certainly could have misunderstood parts of what Supt. Rideout said about the officers developing a plan en route to the Airport.

Taking all this evidence into consideration, I have concluded that the third paragraph of Chief Superintendent Bent's November 5, 2007, e-mail is inaccurate on this issue. I also conclude that the four RCMP officers who responded to the Dziekanski incident did not develop a plan en route to the Airport to deploy the conducted energy weapon if Mr. Dziekanski did not comply.

Second, I am satisfied that none of the officers stopped to consult with any civilians who were present while walking through the public Meeting Area, and that there was no other discussion among the officers (except for Cst. Bentley's enquiry whether any of the other officers had a conducted energy weapon).

Third, I am satisfied that the four officers acted appropriately in walking through the public Meeting Area without stopping to get more information from bystanders. Their first priority was to get to the person who was the subject of the dispatch and, once there, to make an assessment of the circumstances and how they should respond.

2. The officers' initial observations of Mr. Dziekanski

As the four officers approached the handrailing near the swinging glass doors that separated the public Meeting Area from the International Reception Lounge, they saw Mr. Dziekanski and were able to make an initial assessment of him. Although their individual accounts vary to some extent, overall they paint a fairly consistent picture of a man who was unkempt and sweating, breathing heavily, disoriented, agitated, perhaps emotionally disturbed, and wearing a wide-eyed, glazed look. He was standing there or pacing back and forth, with his hands at his side. These observations are consistent with what one sees on the Pritchard video. Mr. Dziekanski was cooperative when the officers initially engaged him. One officer said that Mr. Dziekanski was initially calm; while he did not expect Mr. Dziekanski might start a fight, he wanted to be prepared for it. Another officer thought that he might be intoxicated, although he did not smell any alcohol.

None of the officers saw any broken glass or any luggage that had been thrown around, although one said there was debris around his feet, which likely refers to the broken computer and folding table.

The Pritchard video shows the officers climbing over the handrailing as they approached the swinging glass doors. I do not fault them for doing so. Glass panels prevented them from going under the railing, and walking back and around the railing would have unreasonably delayed their primary goal of getting to the scene and making an assessment as promptly as possible.

3. Entering the secure area

Cst. Bentley was the first officer to climb over the handrailing. After doing so and then approaching the swinging glass doors, he said to Mr. Dziekanski, "Hi, how are you, sir? How's it going, bud?" I accept his evidence that he had not heard anyone say that Mr. Dziekanski did not speak English. From the Pritchard video, I am satisfied that his statements were an appropriate first step in making contact with Mr. Dziekanski, and that he used a conversational tone. Not surprisingly, Mr. Dziekanski did not respond. He was, according to Cst. Bentley, calm and cooperative, and his hands were at his side.

According to the use-of-force experts, Cst. Bentley's initiative in speaking to Mr. Dziekanski made him the contact officer. In the normal course of events, Cst. Bentley would be expected to continue to take the lead role in engaging with Mr. Dziekanski. Constables Rundel and Millington would adopt the role of cover officers, holding back but being ready to intervene if necessary, and Cpl. Robinson would act as supervising officer, observing the overall incident and being ready to take over the role of contact officer if he concluded that Cst. Bentley was not capable of continuing in that role.

There was disagreement among the use-of-force experts as to whether it was appropriate for Cst. Bentley to take the lead role. Sgt. Fawcett and Cpl. Gillis expressed the opinion that Cpl. Robinson acted appropriately in allowing one of his subordinates to take the lead, as that is the only way that junior officers can acquire command experience. Dr. Webster took the opposite view, for two reasons. First, the nature of the call was unusual – to be dispatched to the Airport in response to a possibly intoxicated man damaging property. Second, Cst. Bentley had the least field experience of the four officers.

In my view, Cst. Bentley cannot be faulted for initiating contact with Mr. Dziekanski, and Cpl. Robinson cannot be faulted for allowing Cst. Bentley to take the lead role. While it may have been unusual to respond to a call of this type in an Airport setting, it would not be at all unusual to respond to a call of a possibly intoxicated man causing property damage in any number of other community settings. Cst. Bentley had 16 months of field experience after graduating from Depot, and it was reasonable for Cpl. Robinson to conclude that he had sufficient practical experience to take the lead, based on the dispatch information they had received and what Cpl. Robinson personally observed as they approached Mr. Dziekanski. While there may be honestly held differences of opinion on this issue, it was ultimately a judgement call for Cpl. Robinson. I am satisfied he acted appropriately in allowing Cst. Bentley to take the lead.

However, the respective roles of the four officers changed twice, and dramatically, within the next 15 seconds. The first change occurred when Cst. Millington took over as contact officer. Knowing that Mr. Dziekanski did not speak English, he pushed his hands toward the floor in an attempt to get Mr. Dziekanski to calm down. He also said "passport" and "identification," and when Mr. Dziekanski did not seem to understand, he mimed writing with a pen. Mr. Dziekanski turned and, according to the Pritchard video, made a very tentative downward movement toward the nearby luggage.

Based on the evidence of the use-of-force experts, I consider Cst. Millington's unilateral decision to take over as contact officer, while well-intentioned, to have been an error of judgement, especially since he gave no prior communication to Cst. Bentley or the other officers. There is no suggestion that Cst. Bentley was incapable of continuing as contact officer, and no evidence that Mr. Dziekanski, by his actions, was expressing a preference to deal with Cst. Millington. His intervention may also have added to Mr. Dziekanski's confusion. Nevertheless, having taken on this role, Cst. Millington's request for passport and identification was reasonable and appropriate in establishing whom they were dealing with and as a first step in finding a way to communicate with a person who he realized did not speak English.

The second change occurred when Mr. Dziekanski made a tentative movement downward toward the luggage, captured at 3:37 on the Pritchard video. I interpret that movement as Mr. Dziekanski's attempt to retrieve his travel documents from his luggage. Although the video does not capture the audio, I accept Cpl. Robinson's testimony that at this point he stepped in and took charge. He said, "No. Stop" in what Cst. Rundel described as an authoritative, stern voice, and made a hand gesture conveying the message, "You are not going into your luggage." The video shows Cpl. Robinson's arm coming up, pointing generally in Mr. Dziekanski's direction. According to Cpl. Robinson, Mr. Dziekanski stopped going toward his luggage and was thus complying with his direction. The video confirms this – Mr. Dziekanski returned to a normal, upright stance, with his arms at his side, engaging in eye contact with the officers (3:39).

Was it appropriate or necessary for Cpl. Robinson to intervene in this manner at this time? In my view, it was not. There are several aspects of Cpl. Robinson's intervention that warrant comment:

- I am not persuaded that it was necessary for Cpl. Robinson to intervene at all. Cst. Millington was by now the contact officer, and if he had concerns about Mr. Dziekanski opening his luggage, he was (according to the Pritchard video) the officer closest to Mr. Dziekanski and was capable of taking action to prevent that from happening.
- I am not persuaded that Cpl. Robinson's "No. Stop" order was an appropriate response to Mr. Dziekanski's tentative movement toward his luggage. While I accept that in some circumstances there is a risk that a subject reaching into a jacket or bag might pull out a weapon, this was a remote possibility in the circumstances facing these officers. Mr. Dziekanski was alone, with four police officers facing him. His movement toward the luggage was a predictable and reasonable response to Cst. Millington's request for his passport and identification. He had been, by the officers' own testimony, calm and cooperative since their arrival. The Pritchard video shows Mr. Dziekanski with his arms at his side, engaging in eye contact with the officers. While he may have damaged property before the officers' arrival, he showed no

> signs of animosity or hostility toward them. He was disheveled and agitated, but appeared to understand what was being asked of him and was apparently attempting to comply. In my view, Cpl. Robinson's response was an inappropriately aggressive reaction in the circumstances.

4. Mr. Dziekanski's movement toward the counter

The Pritchard video shows that two seconds later (3:41) Mr. Dziekanski threw up his arms, lowered his head, and turned away from the officers, moving toward the nearby counter. As he did so, Cpl. Robinson moved closer behind him with his arm outstretched, pointing toward the counter. During this sequence (at 3:43), Mr. Dziekanski said, in translation, "Leave me alone. Leave me alone! Did you become stupid? *Or,* Are you out of your mind? *Or,* Have you lost your minds? *Or,* Have you gone insane? Why?"

Cpl. Robinson testified that he pointed with his finger and motioned with his hands for Mr. Dziekanski to put his hands on the counter, and told him to put his hands on the counter. He conceded that Mr. Dziekanski would not have understood his verbal instruction. In their testimony, Constables Bentley and Millington described this behaviour of Mr. Dziekanski as defiant. Cst. Rundel, who described it as resistant, paraphrased the behaviour as, "To hell with you guys, I'm out of here."

I have reached several conclusions about this sequence of events. I am satisfied that Mr. Dziekanski understood and complied with Cpl. Robinson's command not to go into his luggage. Then, two seconds later, Mr. Dziekanski threw up his arms, turned away from the officers, and began moving toward the counter. I am satisfied that Mr. Dziekanski took this action on his own initiative and not in response to a command from any of the officers. This conclusion is consistent with my interpretation of the Pritchard video and with the testimony of the three constables.

There is a dispute in the evidence as to how this action by Mr. Dziekanski should be characterized. A majority of the officers described it as defiant or resistant, and two use-of-force experts (Sgt. Fawcett and Cpl. Gillis) supported that view. Indeed, these two experts expressed the opinion that Mr. Dziekanski's turning and moving away from the officers amounted to “resistant” behaviour as then defined in the RCMP’s Incident Management/Intervention Model, justifying deployment of an intermediate weapon or device, including a conducted energy weapon. The opposing interpretation, expressed by Mr. Nickel and Dr. Webster, was that Mr. Dziekanski was acting out of frustration after receiving contradictory instructions by Cst. Millington and Cpl. Robinson.

I favour the latter interpretation. Having been asked to produce identification and having begun to get them from his luggage, only to be told in an authoritative manner not to do so, we can now infer through the English translation of his comments (“Leave me alone. Have you lost your minds?”) that these contradictory demands frustrated him. His throwing up his arms and beginning to move away from the officers is entirely consistent with this reaction. At this point in time, the only commands he had been given were to calm down and not to go into his luggage. He had not been told to stay where he was, so his moving away from the officers can hardly be characterized as resistant or defiant behaviour. There is no evidence that he was acting contrary to a direction or command from any of the officers. In my view, Mr. Dziekanski was neither resistant nor defiant, and the officers did not honestly believe that he was.

The video shows that as Mr. Dziekanski moved toward the counter, Cpl. Robinson followed close behind, pointing toward the counter (3:42-3:44). I am satisfied that it was only after Mr. Dziekanski began moving away from the officers that Cpl. Robinson began directing him toward the counter. When he did so, the video shows that Mr. Dziekanski did in fact move to the counter, which I interpret as him acting in compliance with Cpl. Robinson’s direction. While I accept Cpl. Robinson’s testimony that he wanted Mr. Dziekanski to place his hands on the counter, the Pritchard video does not capture any verbal instructions to do so, and the video is unclear as to whether Cpl. Robinson made any hand gestures other than pointing toward the counter. I am not satisfied that Mr. Dziekanski understood any direction to place his hands on the counter. He would not have understood Cpl. Robinson’s verbal command, and since Cpl. Robinson was moving up behind him, Mr. Dziekanski may not have seen any hand gestures or, if he did, understood their meaning. In short, I am satisfied that Mr. Dziekanski moved to the counter in compliance with Cpl. Robinson's direction.

5. Picking up the stapler

On the Pritchard video, Mr. Dziekanski reached the counter by 3:44. He turned and faced Cpl. Robinson. At 3:45, Mr. Dziekanski shuffled backward a step and rotated to his right. Although Mr. Dziekanski's image and actions are partially obscured by a reflection on the glass partition through which Mr. Pritchard was filming, it is not in dispute that at this point in the sequence Mr. Dziekanski picked up a stapler that was sitting on the counter. At 3:46, Cst. Bentley appeared to react to something he saw by positioning himself farther to Mr. Dziekanski's right until he disappeared from view.

At 3:47, Cpl. Robinson pulled out his baton and held it at head height, but did not extend it. The video shows Mr. Dziekanski with his upper arms down against his torso, but his lower arms and hands are not visible. At 3:48, Mr. Dziekanski's upper arms came away from his torso. He was looking at Cpl. Robinson. At 3:49, Mr. Dziekanski said something, which may have been, in translation, "Police, police." Cpl. Robinson raised his left arm and pointed at Mr. Dziekanski, and one hears the snap of Cst. Millington deploying the conducted energy weapon.

In addition to the Pritchard video, we have the testimony of the four officers, as well as their police notes and the written statements they gave to members of the Integrated Homicide Investigation Team. Earlier in this part, I summarized this evidence. From my review of this evidence, two matters were in dispute – whether Mr. Dziekanski brandished the stapler toward one or more of the officers in a threatening manner and whether he took one or more steps toward one or more of the officers, while holding the stapler. I will deal with each in turn.

a. Whether Mr. Dziekanski brandished the stapler

In his first statement to the Integrated Homicide Investigation Team (IHIT), Cst. Rundel said that Mr. Dziekanski put the stapler above his head and made motions with it toward the officers. In his second statement to IHIT, he said that Mr. Dziekanski motioned toward the officers with the stapler in an aggressive, combative style. In his testimony, he did not recall Mr. Dziekanski motioning toward him with the stapler or shooting staples out of it. He clarified that when he had referred in his IHIT statements to the stapler being above Mr. Dziekanski's head and making motions toward the officers with it, he was referring to after the second deployment of the conducted energy weapon.

In his police notes, Cst. Bentley stated that Mr. Dziekanski grabbed the stapler and came at the members screaming. In his testimony he agreed that this was incorrect, but later testified that it was somewhat accurate, just out of sequence. It was his screaming and body movement after being hit with the TASER that caused him to move forward. Cst. Bentley testified that when Mr. Dziekanski swung the stapler around, it came within a foot or two of him, and he thought he was going to be hit with it. The stapler was in the closed position, and it was not pointed at him.

Cst. Millington testified that when Mr. Dziekanski picked up the stapler, he held it in one hand and started to approach the officers with hands up.

Cpl. Robinson testified that Mr. Dziekanski was clenching the stapler in his fist. He made motions with his fist and a couple of staples discharged.

Three civilian witnesses, whose testimony I summarized in Part 5, addressed this issue:

- Ms. Ashrafinia said that she saw a stapler in Mr. Dziekanski's hand, but he did not make a movement with it toward the police.
- Mr. Arora agreed that in his statement to IHIT he had said that Mr. Dziekanski grabbed the stapler and tried to swing it toward the officers.
- Mr. Rudek said that Mr. Dziekanski waved the stapler around at the officers, held it out directly in front of himself, and started pressing it and staples came out.

Based on my review of all of this evidence, I am satisfied that after Mr. Dziekanski picked up the stapler, he held it in his right hand, in front of him, at or below his chest level. His left hand was also in front of him, at or below his chest level. I am satisfied that he did not brandish the stapler, either by placing it above his head or motioning with it in an aggressive manner toward any of the officers – either of those actions would have been caught on the Pritchard video. The video contradicts Cst. Bentley's assertion that Mr. Dziekanski swung the stapler within one or two feet of him. Further, I do not believe that any of the four officers thought that Mr. Dziekanski was brandishing the stapler.

I feel compelled to comment on the testimony of two of the officers:

- Cst. Rundel sought to clarify that when he had referred in his IHIT statements to the stapler being above Mr. Dziekanski's head and making motions toward the officers with it, he was referring to after the second deployment of the conducted energy weapon.
- Cst. Bentley sought to clarify the entry in his police notes (to the effect that Mr. Dziekanski grabbed the stapler and came at the members screaming) by stating that it was somewhat accurate, just out of sequence – it was his screaming and body movement after being TASERed that caused him to move forward.

I reject both of these after-the-fact rationalizations as patently unbelievable. They were both, in my view, desperate attempts to explain away important inaccuracies in their police notes and statements to homicide investigators. I think the public is entitled to expect that officers involved in a serious investigation, especially a police-related death, will apply care and professional judgement in how they record their recollection of important events, especially when giving a statement to a homicide investigator. These two officers failed that test miserably. The public is equally entitled to expect that when officers testify under oath, they will be candid and forthright, and if their earlier notes or statements are shown to be inaccurate (as the Pritchard video showed in this case), they acknowledge the inaccuracy. These two officers did just the opposite by offering revisionist interpretations of their previous statements that were unbelievable.

b. Whether Mr. Dziekanski took one or more steps toward one or more of the officers

According to Cst. Rundel, Mr. Dziekanski stepped forward with his left foot while he was holding the stapler.

Although Cst. Bentley wrote in his police notes that Mr. Dziekanski came screaming at them with the stapler, in his testimony he conceded that that account was incorrect.

According to Cst. Millington, when Mr. Dziekanski picked up the stapler, he held it in one hand and started to approach the officers with hands up.

According to Cpl. Robinson, Mr. Dziekanski took a step forward with the clenched fist, at which point Cpl. Robinson pulled out his baton and instructed Cst. Millington to deploy the conducted energy weapon.

Two civilian witnesses, whose testimony I summarized in Part 5, addressed this issue:

- Mr. Meltzer agreed that in his statement to IHIT investigators he had said that Mr. Dziekanski made a motion like he was going to go toward an officer while he held the stapler up in the air; and
- Mr. Ginter said that after grabbing the stapler, Mr. Dziekanski moved toward the officers.

In support of the officers' assertions that Mr. Dziekanski stepped toward them while clenching the stapler in his fist, a forensic video analyst gave expert evidence. In response, counsel for a participant called two experts in photogrammetry. Earlier in this part, I summarized the testimony of these three witnesses.

From my review of this evidence and the Pritchard video, I have concluded that Mr. Dziekanski did not step toward one or more of the officers while clenching the stapler. I will explain why.

Mr. Fredericks testified that from his repetitive viewing of a three-second segment of a stabilized version of the Pritchard video, he identified Mr. Dziekanski take three distinct steps forward (right, left, right), based on his analysis of shoulder movements, although he could not say what distance he moved forward. He acknowledged that he could not see Mr. Dziekanski's legs or feet, and had no special expertise in biomechanics or the study of human motion. In order to verify these findings, Mr. Fredericks measured changes in the size of a movable object (Mr. Dziekanski's jacket), as opposed to changes in the size of a fixed object (the counter), as Mr. Pritchard's video zoomed out during the three-second segment. He concluded that the jacket reduced in size more than the counter, from which he concluded that Mr. Dziekanski was clearly moving away from the camera and toward the officers.

I am not prepared to rely on Mr. Fredericks' analysis for two reasons:

- ***His verification methodology was flawed*** – while I accept that his measurement of the fixed object (the counter) showed a decrease in size as the camera zoomed out, he could make no comparable measurement of the movable object (Mr. Dziekanski's jacket), because he was not able to measure the entire length of the jacket, as it extended below the level of the counter. I accept the opinions of Mr. Hird-Rutter and Mr. McInnis on this issue.
- ***He has no special expertise in determining steps from shoulder movements*** – without the verification referred to above, Mr. Fredericks' opinion of three distinct steps forward is based entirely on his repetitive viewing of the three-second segment of the Pritchard video and his interpretation of Mr. Dziekanski's changing shoulder movements. I am not persuaded that his expertise as a forensic video analyst extends to this type of human body movement. In the absence of such expertise, his opinion deserves no greater weight than the opinion of any other careful observer. I have watched this segment of the Pritchard video many dozens of times, and I have been unable to detect the three methodical step movements Mr. Fredericks described. Even if I am wrong and Mr. Dziekanski did take three distinct steps forward, Mr. Fredericks' opinion is of questionable significance, since he repeatedly refused to estimate distance, even a distance as small as one inch.

6. Deployment of the conducted energy weapon

In his testimony, Cst. Millington gave his rationale for deploying the conducted energy weapon in probe mode against Mr. Dziekanski:

> He had the stapler open, his other fist raised. He's – was in a combative stance, as we call it, and was approaching the officers, I believe, with the intent to attack. So I deployed the TASER at that point.[216]

He clarified that Mr. Dziekanski was approaching either Cst. Rundel or Cpl. Robinson, not Cst. Bentley or himself. He deployed the weapon on his own initiative, without any instruction from another officer to do so.

In his testimony, Cpl. Robinson said that when Mr. Dziekanski took a step forward with the stapler in his clenched fist, that was combative behaviour, and he instructed Cst. Millington to deploy the conducted energy weapon. Although he had pulled his baton out, he considered it preferable to deploy the conducted energy weapon instead of the baton, because the conducted energy weapon can give instantaneous control and creates less risk of injury to the subject. Given Mr. Dziekanski's combative nature (grabbing the stapler and taking a step forward) there was no time to issue the TASER warning before deploying it.

From my review of the evidence, I have reached several preliminary conclusions. First, two of the officers had independently decided to deploy the conducted energy weapon, and the other two officers were not surprised when they heard it being deployed. Second, I am satisfied that Cst. Millington did not hear Cpl. Robinson's instruction to deploy the weapon, and deployed it of his own initiative. Third, both Cst. Millington and Cpl. Robinson gave three reasons for deploying the weapon – Mr. Dziekanski's combative nature or stance, his clenching the stapler in his raised fist, and his stepping toward the officers. Fourth, Cst. Millington testified that he believed that Mr. Dziekanski intended to attack, and Cpl. Robinson's testimony was to the same effect.

It is not my role as Commissioner to pass judgement on whether or not Cst. Millington was justified under s. 25 of the *Criminal Code* in deploying the conducted energy weapon in these circumstances. That is a legal determination properly left to the Criminal Justice Branch of the Ministry of Attorney General, and to the courts.

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[216] Transcript, March 2, 2009, p. 23.

Indeed, it is not open to a provincial commission of inquiry to make findings of criminal or civil liability, and I have no intention of doing so.

Having said that, I think it is appropriate for a commission of inquiry to go beyond a mere recitation of the facts and to analyze the officers' actions in the context of the factual circumstances they faced, the training they had received, and the RCMP's policies under which they operated. I am authorized to make findings of misconduct if I consider it necessary to do so and to make recommendations on any aspect of my mandate. Analyzing the officers' actions and drawing conclusions from them are prerequisites to these two functions.

In my view, Cst. Millington was not justified in deploying the conducted energy weapon against Mr. Dziekanski, given the totality of the circumstances he was facing at that time. Similarly, Cpl. Robinson was not justified in instructing him to deploy the weapon. Further, I do not believe that either of these officers honestly perceived that Mr. Dziekanski was intending to attack them or the other officers. I have reached these conclusions for the following reasons.

First, both Cst. Millington and Cpl. Robinson cited Mr. Dziekanski's stepping forward as one of the justifications for deploying the weapon. I have previously concluded that Mr. Dziekanski did not step forward, and I do not believe that either officer honestly perceived that he did so.

Second, two of the use-of-force experts, Sgt. Fawcett and Cpl. Gillis, testified that when Mr. Dziekanski picked up the stapler, held it in his right fist, and started advancing toward the officers, he displayed combative behaviour, and assuming that Cst. Millington perceived this as a threat to the officers, his deployment of the weapon was consistent with training. Since I have concluded that Mr. Dziekanski did not advance toward the officers and that I do not believe that Cst. Millington and Cpl. Robinson honestly perceived that he did so, one of the crucial assumptions underlying their opinions has not been established, which means that I should place significantly less reliance on their opinions on this issue.

Third, I summarized the testimony of Sgt. Fawcett and Cpl. Gillis in considerable detail earlier in this part, and have since reviewed their evidence with great care. In his written opinion, Sgt. Fawcett concluded, "The officers' actions were consistent with their Common Law duties, various *Criminal Code* (Canada) provisions and RCMP policy and training." Similarly, Cpl. Gillis testified that Cst. Millington responded consistent with his training and with an industry standard; there was nothing that he did wrong in this incident.

Both officers applied what I will call a mechanistic approach to the incident. For example, Sgt. Fawcett testified that Mr. Dziekanski had violently damaged property before they arrived. They initially attempted to communicate with him using Officer Presence and Communication; perceived him to be aggressive, combative, and agitated; triangulated on him in order to reduce his options and to force him to choose which officer he will attack; and commanded him to place his hands on the counter. He armed himself with a stapler, which they believed he would use as a weapon, and displayed assaultive behaviour. They increased the precautionary gap because of his pre-assaultive cues and precluded Physical Control because Mr. Dziekanski was armed and had previously demonstrated violence. The use of other Intermediate Weapons could be precluded as ineffective or inappropriate, and it was reasonable to consider use of the conducted energy weapon given the dispatch information of an intoxicated, aggressive, and violent male.

I do not find this "one step led to the next" analysis particularly helpful, in part because it focuses exclusively on Mr. Dziekanski's behaviours (rather than viewing the incident as a "dance" between him and the officers, as Dr. Webster described it), and also because I do not agree with Sgt. Fawcett's interpretation of some of the events. For example, I do not think that the Pritchard video supports a perception by the officers that Mr. Dziekanski was aggressive or combative. Further, much of Sgt. Fawcett's analysis is premised on Mr. Dziekanski's allegedly violent behaviour prior to the arrival of the officers. While it is true that Mr. Dziekanski had damaged some computer equipment and had thrown a small folding table against a glass partition, *he* *did not display aggression toward anyone, and in any event, he showed no signs of aggression or hostility to the officers.* Sgt. Fawcett's evaluation of the officers' conduct does not appear to be based on an accurate assessment of the circumstances they found upon their contact with Mr. Dziekanski, but upon the information contained in the dispatch.

Fourth, Sgt. Fawcett and Cpl. Gillis led me to believe that their use-of-force analysis was the complete paradigm within which an officer's conduct should be evaluated. While I recognize that there are Officer Presence and Communication aspects of the model, the model is in my view principally a force-centric model – it invites officers to evaluate the situations they face and to make their risk assessments with a "what level of force should I respond with in order to control the situation" analysis. Sgt. Fawcett gave no indication that his analysis of an officer's conduct would be any different if the subject were emotionally disturbed or mentally ill. Cpl. Gillis told me there is a professional expectation that an officer will be empathetic to the situation that a subject finds himself in, but that does not preclude the officer's duty to act, to resolve the situation, or to establish a degree of control. He acknowledged that de-escalation techniques and verbal crisis-intervention matters form part of recruits' use-of-force training and advanced field training. However, he emphasized that he was a subject matter expert in use of force and that the RCMP has a different subject matter expert in relation to mental health crisis intervention training, as though the two are quite discrete and the latter plays no part in his analysis of use of force.

I reject that type of compartmentalization. The RCMP's IM/IM (Exhibit 91) includes both. For example, the sixth principle underlying the model states, "The best strategy is to utilize the least amount of intervention to manage the risk." In making risk assessments, officers are taught that one of the factors to be considered is "the emotional state of individuals involved." One of the response options available to officers (depending on the outcome of their risk assessment) is "verbal intervention," which includes consideration of crisis intervention techniques, verbal and non-verbal communication, anger management, and conflict resolution. It is recommended that officers be patient, be prepared to adapt to diverse people's needs and behaviours, be open and non-defensive, and be empathetic. One of the non-verbal communication skills recommended, as appropriate, is to "sit to indicate you are in no hurry."

Fifth, in my view, neither Cst. Millington nor Cpl. Robinson carried out an appropriate reassessment of risk immediately before deployment of the conducted energy weapon. While the initial dispatch information gave them reason to believe that they might be dealing with a possibly intoxicated man who was damaging property, the circumstances they were faced with upon arrival at the International Reception Lounge painted a very different picture, requiring a reassessment of the risk. Mr. Dziekanski was standing just inside the swinging glass doors with his arms at his side. Although he was clearly disheveled and agitated, he showed no animosity or hostility toward the officers and was compliant with Cst. Millington's and Cpl. Robinson's commands. There was no evidence of broken glass.

From their training they understood the importance of constantly reassessing the risk during an incident and that in assessing risk it was important to take into account the subject's emotional state. In my view, they did neither. They approached the incident as though responding to a barroom brawl and failed to shift gears when they realized that they were dealing with an obviously distraught traveller. This blinkered approach led to an inappropriately aggressive response by Cpl. Robinson that heightened the intensity of the incident, when a more comprehensive risk assessment would have prompted a qualitatively different response that de-escalated the tension and responded to Mr. Dziekanski's needs.

While I consider Cst. Millington's decision to deploy the weapon and Cpl. Robinson's instruction to do so to have been unjustified in the circumstances, with horrendous consequences, I am equally critical of the policy and training paradigm that fosters such poor decision-making. This case cannot be dismissed as two officers having exercised poor judgement through an incomplete risk assessment that discounted Mr. Dziekanski's emotional state. The force-centric analysis they applied to the circumstances they faced appears to me to have been entirely predictable, given the similarly blinkered approach taken by Sgt. Fawcett and Cpl. Gillis in their evaluations and analyses.

I interpret the expert testimony of these two senior and experienced officers as reflecting the use-of-force training that occurs within the RCMP at large and in BC's municipal police departments. If that is so, it troubles me greatly. It is, without a doubt, essential that officers be trained in the use of force because many situations they face will require the use of force to protect the public and themselves, and to restore public order. But that is only half the story. Many situations can be, and should be, resolved without force, and the skills and techniques that facilitate the non-physical resolution of such incidents should be an integral part of not only use-of-force training but also post-incident evaluations and analyses.

7. Multiple deployments of the weapon, leading to Mr. Dziekanski's restraint

Cst. Millington initially deployed the conducted energy weapon in probe mode. One of the probes lodged in Mr. Dziekanski's chest, and it appears likely that the other probe lodged in the lower portion of his shirt, which was flapping loose against his body. The deployment lasted for six seconds (3:49-3:55), which means that Cst. Millington held the trigger down for that entire time period. If he had pulled the trigger and then released it (as officers are trained to do), the weapon would have discharged for only five seconds.

I accept Cst. Baltzer's testimony that after one second of normal discharge, he heard clacking that indicated intermittent discharge of electrical current thereafter. In other words, the weapon was having some, but not full, effect on Mr. Dziekanski.

The Pritchard video records the sound of this first weapon deployment. Immediately after the commencement of the electrical discharge, Mr. Dziekanski began screaming, with his arms flailing in front of him. He stumbled to his right, away from Cst. Millington, and he had fallen to the floor by the six-second mark.

One second after completion of the first weapon deployment, Cst. Millington deployed the weapon again, in probe mode. This deployment lasted for five seconds (3:56-4:01), which is consistent with Cst. Millington having pulled the trigger and then releasing it. According to Cst. Baltzer, clacking was heard during the first one-and-a-half to two seconds (indicating intermittent discharge of the electrical current), but not thereafter (indicating that Mr. Dziekanski would have felt the effects of the electrical current). During this time period, the Pritchard video shows Mr. Dziekanski on the floor, screaming, with his arms and hands held tightly against his chest, his body partially curled up, his legs thrashing, and his body moving around in a circular motion, which several witnesses described as "turtling." The officers moved in to surround Mr. Dziekanski during this period, but no one actually took steps to restrain him.

The weapon data download shows that there was a 12-second break after completion of the second deployment, before Cst. Millington deployed the weapon a third time in probe mode. During that interval, the Pritchard video shows Mr. Dziekanski continuing to scream and "turtle" around on the floor and three of the officers moving in and attempting to restrain him.

During this 12-second interval, Cpl. Robinson instructed Cst. Millington to deploy the conducted energy weapon again, which he did. This third deployment lasted for five seconds (4:13-4:18), which is consistent with Cst. Millington having pulled the trigger and then releasing it. According to Cst. Baltzer, no clacking sound was heard, which indicates that Mr. Dziekanski would have felt the full effect of the electrical current for the full five seconds. During this period, the Pritchard video shows the three officers struggling to restrain Mr. Dziekanski.

After a four-second break, Cst. Millington deployed the weapon a fourth time, this time in push-stun mode. According to Cst. Baltzer, this deployment lasted for nine seconds (4:22-4:31), but he could not determine whether there was any intermittent discharge. I accept Cst. Millington's testimony that he deployed it against Mr. Dziekanski's upper back shoulder area for pain compliance purposes, to persuade

Mr. Dziekanski to let the officers pull his arms behind his back and handcuff him. During this period, the Pritchard video is partially obscured by people walking in front of the camera, but one can still see the officers struggling with Mr. Dziekanski, who is making guttural sounds.

After a two-second break, Cst. Millington deployed the weapon a fifth time, again in push-stun mode. According to Cst. Baltzer, this deployment lasted for six seconds (4:33–4:39), but he could not determine whether there was any intermittent discharge. Cst. Millington testified that he had no recollection of this deployment. During this period, the Pritchard video is again partially obscured by people walking in front of the camera, but one can still see the officers struggling with Mr. Dziekanski.

Between 4:50 and 5:00, the sounds coming from Mr. Dziekanski became more moderated, and the struggle wound down. I conclude that it was during this period that the handcuffs were applied.

In their police notes and statements to the IHIT investigators, and in their testimony at our evidentiary hearings, the four officers described some aspects of these events differently from what one sees on the video:

- In his statement to an IHIT investigator, Cst. Rundel said that he and two other officers wrestled Mr. Dziekanski to the ground. In his testimony, he agreed that this was not accurate. He testified that during the first deployment, Mr. Dziekanski remained standing in a combative posture, with his fists clenched. Mr. Dziekanski appeared to be almost fighting through it. Cpl. Robinson ordered Cst. Millington to deploy the weapon again while Mr. Dziekanski was still standing, which caused Mr. Dziekanski to release the stapler and fall to the ground.
- In his statement to an IHIT investigator, Cst. Bentley said that Cpl. Robinson and Cst. Rundel took Mr. Dziekanski down. In his testimony, he agreed that this was inaccurate. He testified that he believed Mr. Dziekanski was trying to fight through the first deployment of the conducted energy weapon. His recollection was that Mr. Dziekanski was still standing when Cpl. Robinson instructed Cst. Millington, "Hit him again," although he may have collapsed to the floor before the weapon was deployed.
- In his police notes and statements to IHIT investigators, Cst. Millington said that the officers wrestled Mr. Dziekanski to the ground. In his

testimony, he agreed that those passages were in error. In one of his statements to IHIT investigators, he said that he cycled the weapon twice because Mr. Dziekanski was still standing after the first deployment. In his testimony, he agreed that this was wrong, although he believed at the time that Mr. Dziekanski was still standing at the completion of the first discharge, which is why he discharged it a second time.

- In his statement to an IHIT investigator, Cpl. Robinson said that the officers had to wrestle Mr. Dziekanski to the ground. In testimony, Cpl. Robinson agreed that he was mistaken – at certain points he did wrestle with him, but Mr. Dziekanski did drop to the ground. He also testified that Mr. Dziekanski did not fall to the ground from the first deployment, so he gave the command for Cst. Millington to deploy the weapon again, while Mr. Dziekanski was still standing. When it was pointed out to Cpl. Robinson that his "Hit him again" statement is heard on the Pritchard video about 18 seconds after Mr. Dziekanski fell to the ground, he testified that he must have given an earlier "Hit him again" command that was not captured on the video (or testified to by any other witness).

As discussed earlier, in my view, the initial deployment of the conducted energy weapon was not justified, given the totality of the circumstances facing the officers. Arguably, all subsequent deployments were thus unjustified. Nevertheless, I think it is important to review, and comment on, the conduct of the officers following the initial deployment:

- I am satisfied that Mr. Dziekanski had fallen to the floor by the time the first weapon deployment had finished.
- I reject the suggestion that, during the first deployment, Mr. Dziekanski was combative and appeared to be fighting through the electrical discharge. The intermittent discharge may explain why he did not immediately fall to the ground, but any reasonable viewer of the Pritchard video would conclude that Mr. Dziekanski was reacting convulsively to the extreme pain of the weapon's discharge of electrical current.
- I am not satisfied that Cst. Millington adequately re-assessed the risk (to himself, to the other officers, to the public, and to Mr. Dziekanski) before deploying it the second time. In his testimony, he stated clearly the rationale for the second deployment, "From my training, the effects of the TASER being fired are that the person that it's applied against is supposed to fall immediately, and that's supposed to immobilize him. It did not have that effect on Mr. Dziekanski, so I felt it was necessary

to fire it again, and so I did." Even if Mr. Dziekanski's prior behaviour with the stapler had amounted to resistive behaviour justifying deployment of the weapon (which I reject), the circumstances had dramatically changed before Cst. Millington deployed the weapon the second time – Mr. Dziekanski had dropped the stapler, he was lying on the ground, and he was in obviously intense pain from the discharge. I cannot see, in those changed circumstances, resistive behaviour that justified deployment of the weapon. Indeed, even Cst. Millington gave a different justification for the second deployment – that the first deployment had not immobilized Mr. Dziekanski. In my view, the weapon's failure to immobilize Mr. Dziekanski was not a justification for deploying the weapon a second time. It is ridiculous to suggest that when a subject is lying on the ground, kicking and screaming in pain, an officer is justified in deploying a conducted energy weapon a second time, especially when the officer knows that there are risks associated with multiple deployments.

- For similar reasons, I do not think that Cst. Millington adequately re-assessed the risk before deploying the weapon the third time in probe mode, and I do not think that Cpl. Robinson adequately reassessed the risk before ordering Cst. Millington to do so. By this time Mr. Dziekanski was screaming and "turtling" around on the floor, and the other three officers were wrestling with him, attempting to handcuff his hands behind his back.
- Cst. Rundel, Cst. Bentley, and Cpl. Robinson did not move in to attempt to restrain Mr. Dziekanski until after completion of the second weapon discharge – more than 12 seconds after initiation of the first deployment. It is not in dispute that officers are taught to move in during deployment, because once the electrical discharge ceases, the subject regains normal strength very quickly. In my view, it was reasonable for them not to move in during the first discharge, because Mr. Dziekanski was initially still standing and stumbling backward before falling to the ground. However, during the second discharge he was on the floor screaming in agony, and in my view it was safe for them to move in then, and they acted unreasonably in not doing so.
- Cpl. Robinson testified that during the struggle with Mr. Dziekanski, he positioned his knee across Mr. Dziekanski's shoulder blades. He did this, he said, in accordance with his training in order to prevent Mr. Dziekanski from rolling over or picking himself up. He denied placing his knee on the back of Mr. Dziekanski's neck. The pathologist who performed the autopsy found no evidence of contusion or abrasion to Mr. Dziekanski's neck. The second segment of the Pritchard video shows Mr. Dziekanski lying in the prone position, with Cpl. Robinson kneeling near his head. At 5:09 Cpl. Robinson is seen repositioning

> himself. He places his left knee on the ground behind Mr. Dziekanski's back, and at 5:11 his lower right leg is seen positioned cross-wise above or on Mr. Dziekanski's neck, where it remains until the view is blocked at 5:34. During that period, there is no movement of Mr. Dziekanski's head. It is not in dispute that officers are trained that it is medically unsafe to apply pressure to the back of a subject's neck. From my review of the evidence, I am satisfied that Cpl. Robinson did apply force with his leg to Mr. Dziekanski's neck area when such force was not justified, given the totality of the circumstances he was facing at that time.

The initial claims by all four officers in their police notes and statements to IHIT investigators that they wrestled Mr. Dziekanski to the ground has been shown, by the Pritchard video, to be untrue. These were either innocent inaccuracies by the four officers or deliberate misrepresentations of what had happened. In my view, they were the latter, and they were made for the purpose of justifying their actions. But for the Pritchard video, we would likely never have learned what really happened, and these officers' revisionist accounts would have lived on.

Finally, I reject Cpl. Robinson's testimony that he must have told Cst. Millington, "Hit him again" while Mr. Dziekanski was still standing. There is no credible evidence corroborating this version of events.

8. Attending to Mr. Dziekanski and the arrival of the Richmond firefighters

We are largely dependent on the testimony of the four officers to determine what happened between the times that Mr. Dziekanski was handcuffed and the arrival of the Richmond firefighters. From this evidence, I conclude that Mr. Dziekanski was initially in the prone position (i.e., on his stomach). Within five to ten seconds after being handcuffed he stopped kicking his legs, and he lay motionless while breathing heavily. According to several officers, he was moved into a partial recovery position. Cst. Rundel assisted with a pat-down and quick search of Mr. Dziekanski, and his wallet was found in his jacket.

Cst. Bentley testified that he observed Mr. Dziekanski go unconscious, although he continued to breathe quite loudly. He immediately called dispatch to request that paramedics attend on a routine basis, but shortly thereafter he upgraded the call to Code 3 when he saw Mr. Dziekanski's face turn blue. He realized that they were facing a medical emergency and that cardiopulmonary resuscitation might be required, but took no steps to have a defibrillator brought to the scene, thinking that Cpl. Robinson would take the initiative.

Cst. Rundel did not see any of the other officers check Mr. Dziekanski's pulse, but he did see Cpl. Robinson kneel down next to Mr. Dziekanski and assumed it was to monitor his breathing. Cst. Bentley did not see any of the other officers check Mr. Dziekanski's pulse or breathing, but he did see a man from Airport Operations (Mr. Enchelmaier) check the carotid pulse.

I recognize that Constables Rundel and Bentley had only a limited opportunity to observe, since Cpl. Robinson instructed both of them to go out to their police vehicles to retrieve hobbles and a camera, respectively.

Cst. Millington did not check Mr. Dziekanski's pulse or breathing and did not know whether he was conscious. In his police notes he recorded that he observed Cpl. Robinson check Mr. Dziekanski's pulse every couple of minutes and that Mr. Dziekanski had a pulse, but in his testimony he said only that he asked Cpl. Robinson if Mr. Dziekanski was breathing, and he replied, "Yes."

Cpl. Robinson testified that he constantly monitored Mr. Dziekanski's breathing until the firefighters arrived, by placing his hand on Mr. Dziekanski's chest, observing his mouth for breathing, and placing his head close to Mr. Dziekanski's head so he could hear his breathing. Initially he heard what he thought was snoring, which alerted him to Mr. Dziekanski being unconscious. He was aware that his ear had gone blue; his medical training told him that this could be a medical issue of breathing or bruising. He concluded that it was the latter, since he had established that Mr. Dziekanski was breathing. He testified that he checked Mr. Dziekanski's carotid pulse a couple of times, removing his glove each time.

Mr. Enchelmaier, whose testimony I summarized in Part 5, told me that within seconds of Mr. Dziekanski going unconscious, he and Cpl. Robinson moved him into the recovery position. He observed Cpl. Robinson check Mr. Dziekanski's carotid pulse (with his gloves on) and check his breathing. He also agreed that, to the best of his recollection, Cpl. Robinson leaned over Mr. Dziekanski and conducted an assessment of him until the firefighters arrived. He testified that he (Mr. Enchelmaier) checked Mr. Dziekanski's carotid pulse and breathing three times. The third time, about two minutes before the firefighters arrived, Mr. Dziekanski had a clear and slow pulse and slow, low breathing. He did not notice Mr. Dziekanski's colour going blue and then grey until after the paramedics arrived.

The three firefighters who attended the scene all testified that when they entered the International Reception Lounge, Mr. Dziekanski was lying, handcuffed, in the prone position, not in a partial recovery position, with his head turned to the left. Captain Graeme testified that three officers were standing about 10 metres away from Mr. Dziekanski, and the fourth was standing alone about five metres away. Firefighter Duranleau testified that they were standing 10-15 feet away and no one was touching him. Firefighter Cameron testified that he saw two or three officers standing by Mr. Dziekanski's feet, but no one was at his head.

Based on this evidence, I have reached several conclusions:

- Cst. Bentley acted promptly and prudently to have paramedics dispatched when he realized that Mr. Dziekanski had gone unconscious, and properly upgraded the call to Code 3 when he saw that Mr. Dziekanski was turning blue.
- I am satisfied that the officers, likely with the assistance of Mr. Enchelmaier, placed Mr. Dziekanski into a modified recovery position. However, I am equally satisfied that some time later, Mr. Dziekanski returned to the prone position, because all three firefighters testified that when they arrived they found Mr. Dziekanski lying on his stomach.
- While I am satisfied that Cpl. Robinson did initially check Mr. Dziekanski's carotid pulse and monitored his breathing, I do not accept his evidence that he did so constantly until the firefighters arrived. I prefer the testimony of the firefighters that when they

arrived, none of the four officers was attending to or monitoring Mr. Dziekanski. In my view, Cpl. Robinson, as the senior supervising officer on the scene, should have constantly monitored Mr. Dziekanski's condition and should have provided medical treatment if necessary. I am satisfied that he failed to adequately monitor Mr. Dziekanski's medical condition and/or provide first aid treatment, or direct others under his command to do so, after Mr. Dziekanski had been restrained.

- I am satisfied that soon after Mr. Dziekanski was handcuffed, he lapsed into unconsciousness and his face began turning blue, signifying a medical emergency. Soon thereafter, his pulse and breathing stopped. I will explore in more detail in Part 7 that sequence of events.

9. The Richmond firefighters' assessment

As the three Richmond firefighters entered the International Reception Lounge, one of the police officers told Captain Graeme that the conducted energy weapon had been used on Mr. Dziekanski three times. Captain Graeme asked one of the officers to remove the handcuffs so that they could perform a proper assessment. The officer refused, saying that Mr. Dziekanski had been violent, which frustrated Captain Graeme. Based on the testimony of Cst. Rundel and Cst. Millington, I am satisfied that it was Cpl. Robinson who refused. Cpl. Robinson testified that he had no recollection of such a conversation, but acknowledged that he might have done so.

Captain Graeme instructed Firefighter Duranleau to begin her assessment. She spoke to Mr. Dziekanski but got no response, and performed a pain stimulus check on his neck and again got no response, from which she concluded that he was unconscious. She could see no evidence that he was breathing, and could not get a radial or carotid pulse. No one told her that a conducted energy weapon had been used multiple times or that Mr. Dziekanski had turned blue.

Firefighter Cameron also determined that Mr. Dziekanski was unconscious and not breathing. Anxious to get him onto his back in case they needed to perform CPR or use an automated external defibrillator, he told one of the officers that he needed the handcuffs removed, but his request was refused.

Both Captain Graeme and Firefighter Cameron were surprised that the Airport's Emergency Response Service was not on scene when they arrived – they both testified that ERS always arrived before the firefighters. On this issue I prefer the testimony of Captain Graeme and Firefighter Cameron over the testimony of Robert Ginter, the Airport response coordinator, who told me (see Part 5) that the response time of ERS and the firefighters would have been about equal.

Should the handcuffs have been removed at the firefighters' request? On the one hand, the firefighters clearly wanted them removed so that Firefighter Duranleau could perform her assessment and so that, according to Firefighter Cameron, they would be in a position to perform CPR or use the automated external defibrillator if either was necessary. None of the firefighters felt that their safety was at risk. On the other hand, Cpl. Robinson testified that he believed that Mr. Dziekanski had been violent, and might regain consciousness and be violent again, as Cpl. Robinson had seen with other subjects. According to Cpl. Robinson, he knew that Mr. Dziekanski was unconscious, but believed he was breathing and had a pulse. He was aware that Mr. Dziekanski's ear was blue, but attributed that to bruising, not a breathing problem.

In my view, Cpl. Robinson's refusal to remove the handcuffs can only be justified on the basis of a risk assessment made at the time of the firefighters' request. How serious a risk was there that Mr. Dziekanski would regain consciousness and come up fighting? Earlier in this part, I stated that I rejected Cpl. Robinson's testimony that he constantly monitored Mr. Dziekanski until the firefighters arrived, so he had no basis for assuming that he was still breathing and had a pulse. The unanimous testimony of the three firefighters satisfies me that Mr. Dziekanski had returned to the prone position before their arrival, which further supports my view that Cpl. Robinson did not constantly monitor Mr. Dziekanski.

Taking all these factors into account, Cpl. Robinson did not, in my view, have sufficient up-to-date information to justify refusing to remove the handcuffs for the firefighters. I reach this conclusion without relying on the important evidence that

Mr. Dziekanski's face had already turned blue. While Cst. Bentley said that he saw Mr. Dziekanski's face turn blue 5-10 seconds after he lapsed into unconsciousness, there is no evidence that he communicated this to Cpl. Robinson, who testified that he only saw that Mr. Dziekanski's ear had turned blue, which he attributed to bruising.

In Part 9, I will discuss in more detail the need for the Vancouver Airport Authority, the RCMP, Richmond Fire-Rescue, and the BC Ambulance Service to work together in formulating a plan of action for dealing with police use-of-force incidents at the Vancouver International Airport that evolve into medical emergencies.

10. Arrival of the BC Ambulance Service paramedics

When the two basic life support paramedics arrived on the scene, one of them saw immediately that Mr. Dziekanski's face was bluish in colour and cyanotic. The other paramedic saw, from 40 feet away, that he was very cyanotic and lifeless. When they asked Cpl. Robinson to remove the handcuffs, he initially told them that Mr. Dziekanski had been quite aggressive. However, when the paramedics repeated their request in a firm tone, the handcuffs were removed.

When the two paramedics rolled Mr. Dziekanski onto his back, one of them commented about his colour. His eyes were closed, his lips and tongue were blue, he was not breathing, and he had no carotid pulse. Although the paramedic thought that Mr. Dziekanski was dead, he ordered the firefighters to start oxygen, inserted an oral airway, and instructed Firefighter Duranleau to begin chest compressions. The automated external defibrillator was attached, but it advised "no shock," which meant that there was no shockable rhythm.

About two minutes after their arrival, two advanced life support paramedics arrived. They connected their manual cardiac monitor, which confirmed that Mr. Dziekanski was asystole. Nevertheless, they started to initiate intravenous treatment and medications, and endotracheal intubation. After 20 minutes of resuscitation attempts, one of the paramedics consulted by phone with a Richmond physician, who gave orders to discontinue resuscitation, at which point the paramedic pronounced Mr. Dziekanski dead.

11. Post-incident discussions with the other officers

At about 2:30 a.m., Cpl. Robinson instructed Constables Rundel, Bentley, and Millington to return to the Airport sub-detachment office and to wait for Integrated Homicide Investigation Team officers to attend, when they would be interviewed. Cpl. Robinson testified that he would have told them not to discuss the incident among themselves until after they gave their statements to the IHIT investigators. IHIT investigators interviewed all three officers later that morning.

All four officers remained on active duty at the Airport sub-detachment for several weeks after the Dziekanski incident, and they worked together on some shifts during that period. In late October 2007 the four officers participated in a critical incident debriefing session. Three of them also attended a training course together.

Only one officer (Cst. Bentley) testified that during the critical incident debriefing session, everyone gave his or her version of the events that transpired that night. In all other respects, all four officers testified either that there was never any discussion between or among them about what had happened at the Airport or that they had no recollection of any such discussion. They only talked about their feelings, and the trauma they were going through.

Counsel for one participant alleged, during the evidentiary hearings and in his closing submissions, that following the incident at the Airport the officers discussed what had happened at the Airport and that they collaborated to fabricate their story in the expectation that it would justify their conduct to their superiors. This is a serious allegation that requires consideration. On the one hand, we have the evidence of Staff Sgt. Wright that he instructed Cpl. Robinson to tell the three constables to "sit down, shut up, and make notes, and not talk to one another or talk to anybody else." Cpl. Robinson testified that he would have told the three constables not to discuss the incident among themselves until after they had given their statements to the IHIT investigators. We have the sworn testimony of the four officers that they did not discuss the incident among themselves before giving their statements to the IHIT investigators.

On the other hand, the officers did have an opportunity (i.e., several hours) to discuss the incident among themselves, while at the Airport and later at the sub-detachment office, before the IHIT investigators interviewed them. If they felt that they had acted inappropriately, they also had a motive to collaborate and fabricate a story in order to justify their conduct. Finally, there are similarities in the language the officers used about their interaction with Mr. Dziekanski in their statements to IHIT investigators. For example:

- Mr. Dziekanski raising the stapler:
  - Cst. Rundel – "he started … clenching his fists and … putting the stapler up above his head."
  - Cst. Millington – "he reached and grabbed the stapler, had it in the open position and had it raised high."
  - Cpl. Robinson – "he's swinging the stapler like the um, up high."
- Mr. Dziekanski swinging the stapler:
  - Cst. Millington – "the male swung the stapler wildly with his arm at the members."
  - Cpl. Robinson – "swinging a stapler."
- Mr. Dziekanski advancing toward the officers:
  - Cst. Rundel – "He picked up a stapler […] making motions with it, uh … towards us."
  - Cst. Bentley – "subject grabbed a stapler and came at members screaming."
  - Cst. Millington – "He picked up a stapler and … he was moving towards, towards us."
  - Cpl. Robinson – "I remember him taking a step forward."
- Officers wrestling Mr. Dziekanski to the ground:
  - Cst. Rundel – "… made contact with, with the male, and … wrestled him to the ground."
  - Cst. Bentley – "Constable Rundel moved in and uh, took down the male."
  - Cst. Millington – "Members had to wrestle him to the ground."

  - Cpl. Robinson – "he had to be wrestled to the ground."
- Mr. Dziekanski fighting through the weapon deployment:
  - Cst. Bentley – "The male, uh, appeared to be fighting through the TASER."
  - Cpl. Robinson – "trying to fight through."

Three questions arise. Did the officers discuss the incident? If they did, did that discussion lead to them unintentionally giving similar accounts to the IHIT investigators (what lawyers and judges refer to as "innocent contamination")? Alternatively, did their discussions lead to a decision to collaborate and fabricate a story to justify their conduct (what lawyers and judges call "collusion")?

I will address those three questions in reverse order. When some of the officers' statements are compared, several concerns arise. The statements quoted above tend to overstate or inaccurately describe Mr. Dziekanski's actions in a manner favourable to the officers (i.e., that might justify deployment of the conducted energy weapon). Also, there is some similarity in terminology used (e.g., "wrestled him to the ground"). On the other hand, in most instances, not all the officers used similar language to describe an event, and in several instances the similarities are limited to a description of a particular incident (e.g., advancing toward the officers) rather than the use of identical terminology.

An allegation of collusion is not to be taken lightly – the evidence would have to satisfy me to a high degree of certainty before I would make such a finding. Applying that standard, I am not satisfied that the evidence before me is sufficient to conclude that the four officers colluded to fabricate a story to justify their conduct.

It is, of course, possible that if the officers did discuss the incident, they may have innocently or subconsciously modified the accounts they gave to the IHIT investigators in order to accord with their colleagues' accounts. Many judges have witnessed such innocent contamination. In order to determine whether that occurred in this case, I first must decide whether the officers did in fact discuss the incident, in spite of their sworn testimony to the contrary.

Earlier in this part, I made findings of fact and conclusions that were critical of the four officers. For example:

- When discussing whether Mr. Dziekanski brandished the stapler, I concluded that Cst. Rundel and Cst. Bentley desperately attempted, in their testimony before this Commission, to explain away important inaccuracies in their police notes and statements to IHIT investigators by offering revisionist interpretations of their previous statements, which I found to be unbelievable.
- I concluded that Cst. Millington was not justified in deploying the conducted energy weapon initially, that Cpl. Robinson was not justified in instructing him to do so, and that I did not believe that either officer honestly perceived that Mr. Dziekanski was intending to attack them or the other officers.
- I concluded that the initial claims by all four officers in their police notes and statements to IHIT investigators that they wrestled Mr. Dziekanski to the ground were untrue, and that these were deliberate misrepresentations made for the purpose of justifying their actions.

These findings of fact and conclusions satisfy me of their willingness to repeatedly misrepresent what happened at the Airport for self-serving purposes, to mislead the IHIT investigators, and to continue to do so in front of this Commission, even in the face of such incontrovertible evidence as the Pritchard video. I had ample opportunity to observe the four officers during their lengthy examination at our evidentiary hearings. They stubbornly stuck to their version of events long after it had been shown to be unbelievable, and in their answers they were, at times, evasive. This assessment of them, which I must say I have reached reluctantly after careful consideration (but with a high degree of certainty), undermines their credibility in my eyes.

Taking into account their opportunity to discuss the incident, an understandable motivation to present an account that would justify their conduct, and the similarities in their post-incident statements, I conclude that the four officers did discuss the incident among themselves before they were interviewed by the IHIT investigators. While the evidence does not justify a conclusion that they colluded to fabricate a story, I am satisfied that their discussions resulted in them giving surprisingly similar accounts of the incident that tended to misrepresent what had happened and to portray Mr. Dziekanski's actions in an unfairly negative light and their own actions in an unfairly positive light.

12. Cst. Millington's completion of the conducted energy weapon usage report

Earlier in this part, I was critical of the imprecision with which the officers prepared their police notes and gave their statements to the IHIT investigators. In some instances, I concluded that these were not innocent inaccuracies, but deliberate misrepresentations of what had happened, made for the purpose of justifying their actions. I have reached a similar conclusion respecting Cst. Millington's completion of the usage report that he was required to fill out after deployment of the conducted energy weapon. I quoted the entire CEW usage report earlier in this part, when summarizing Cst. Millington's evidence.

In his testimony, Cst. Millington agreed that several of the statements he made in the usage report were inaccurate, including the following:

- Mr. Dziekanski was not yelling.
- Mr. Dziekanski was not swinging the stapler wildly with his arm at the members.
- The first cycle of the weapon was six seconds, not five seconds.
- After the first weapon deployment, Mr. Dziekanski did not continue to walk toward the officers with his arms raised.
- The other officers did not wrestle Mr. Dziekanski to the floor after the second cycle – he fell to the floor himself after the first cycle.

In addition, Cst. Millington stated in the usage report that Mr. Dziekanski, while holding the stapler, "aggressively moved towards members on scene." I have earlier concluded that Mr. Dziekanski did not move toward the members while holding the stapler.

It is noteworthy that RCMP policy required that a CEW usage report be completed before the end of the officer's shift. In this case, Cst. Millington completed the report several days later, which provided him with ample time for reflection about what had actually happened, and for precision in recording the events surrounding deployment of the conducted energy weapon.

To repeat what I said earlier, I think that the public is entitled to expect that officers involved in a serious investigation, especially a police-related death, will apply care and professional judgement in how they record their recollection of important events. In his completion of this form, Cst. Millington failed this test miserably. He consistently misrepresented and overstated Mr. Dziekanski's behaviours and actions in a manner prejudicial to Mr. Dziekanski, and chose self-serving language for the purpose of justifying his actions. These misstatements portrayed Mr. Dziekanski as combative – behaviour which, if true, would have justified deployment of the conducted energy weapon.

In my view, Cst. Millington could not have so fundamentally mis-recalled the pivotal events of the incident when completing the usage report. To the contrary, I am satisfied that these were deliberate misstatements of Mr. Dziekanski's actions and behaviours, made for the purpose of justifying his deployment of the weapon. But for the Pritchard video, this revisionist account of the incident would have lived on.

13. Concluding comments

Although it has taken many pages to provide a complete accounting of Mr. Dziekanski's interaction with the four RCMP officers, this tragic encounter can be summarized much more succinctly.

When the officers arrived, they found Mr. Dziekanski behind the swinging glass doors leading into the International Reception Lounge. Although unkempt, sweating, and breathing heavily, he was standing calmly with his hands at his side. Cst. Bentley greeted him in an entirely appropriate manner but, due to the language barrier, got no response. When Cst. Millington asked for his passport or identification, Mr. Dziekanski apparently attempted to comply by bending down toward his luggage.

Even when Cpl. Robinson intervened and ordered Mr. Dziekanski in an authoritative, stern voice to stop going toward his luggage, Mr. Dziekanski complied by returning to an upright stance, with his arms at his side, engaging in eye contact with the officers. His statement, "Leave me alone, have you lost your minds?" denotes frustration, presumably from receiving contradictory demands. He threw up his arms, lowered his head, and turned away from the officers. None of those actions breached any of the officers' directions to him.

As Mr. Dziekanski did so, Cpl. Robinson followed close behind, pointing toward the counter. Mr. Dziekanski moved to the counter, another act of compliance. Mr. Dziekanski picked up a stapler in his right hand and, facing the officers, held it in his hand at chest height. In less than five seconds, Cst. Millington deployed the conducted energy weapon against him, even though Mr. Dziekanski had not screamed at, waved the stapler at, or moved toward the officers. No command had been given to drop the stapler, and no warning had been given about the weapon being deployed.

The Pritchard video describes, more accurately and graphically than I can, Mr. Dziekanski screaming in agony, stumbling to his right, falling to the floor, all during the first six-second deployment. During the second deployment, some of which was intermittent, Mr. Dziekanski is seen on the floor, screaming, with his body curled up, his arms and hands held tightly against his chest, his legs thrashing, and his body moving around in a circular motion. The weapon is deployed a third time in probe mode, and then twice in push-stun mode before handcuffs are applied.

What had begun mere seconds earlier as appropriate attempts at contact and communication by Cst. Bentley and Cst. Millington started to go off the rails with Cpl. Robinson's totally unwarranted intervention, and culminated with Cst. Millington's unjustified multiple deployments of the weapon (which Cpl. Robinson sanctioned) against a man who was just standing there. These actions by Cst. Millington and Cpl. Robinson were outrageous, and I condemn those actions in the strongest possible terms.

These two officers grossly misread the situation they were facing. They resorted to force when their training and common sense dictated the employment of de-escalation techniques to calm a distraught traveller.

In my 23 years as a criminal defence lawyer and prosecutor, and in my 16 years as a trial and appellate judge, I have had professional dealings with hundreds, if not thousands, of RCMP officers. Those dealings reinforced the respect I have had for the Mounties since my childhood. The RCMP is an iconic institution in Canada, and for nearly a century its officers have served their country and its citizens with integrity and bravery, often in harsh and dangerous circumstances.

The unprofessional manner in which Cst. Millington and Cpl. Robinson dealt with Mr. Dziekanski, and all four officers' less-than-forthright accounting for their conduct, has had repercussions that extend far beyond this one incident and well beyond this province – Mr. Dziekanski's death appears to have galvanized public antipathy for the Force and its members. That is regrettable. As I have said several times in this report and in my earlier one, the most important weapon in the arsenal of the police is public support.

During the past few years, several other high-profile incidents appear to have undermined public confidence in the RCMP. I cannot comment on these other matters, but I can comment about this one tragic case. At its heart, it is the story of shameful conduct by a few officers. It ought not to reflect unfairly on the many thousands of other RCMP officers who have, through years of public service, protected our communities and earned a well-deserved reputation in doing so.

PART 7

THE CAUSE OF MR. DZIEKANSKI'S DEATH

PART 7: THE CAUSE OF MR. DZIEKANSKI'S DEATH

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A. INTRODUCTION

In this part, I will summarize the opinions of 14 medical experts from various disciplines. I will then draw conclusions about the factors that in my view most likely contributed to Mr. Dziekanski's death. Please refer to the Glossary at the end of this report for definitions of medical terms.

Several points should be kept in mind when considering these medical opinions. Some experts had not had an opportunity to review the opinions of other experts before they prepared their written reports and/or testified at our evidentiary hearings, and consequently, they were not able to comment on those opinions during their testimony. Because of that, Commission Counsel provided them with those other experts' reports and with transcripts of their testimony, and invited them to file supplementary written reports. I have included summaries of these supplementary reports at the end of my summaries of those experts' initial reports and testimony. In addition, some experts have commented on the medical opinions of other experts, when their respective areas of expertise differ.

Finally, the opinions of three other medical experts were filed as exhibits, although they did not testify at our evidentiary hearings. Two of those experts (Drs. Pollanen and Sloane) had prepared reports for the RCMP's Integrated Homicide Investigation Team, and the third (Dr. Di Maio) prepared a report for the Criminal Justice Branch during its charge assessment process. If this were litigation, there would be several problems in considering the opinions of such experts who did not testify:

- They reviewed documents that were provided to them by the RCMP or the Criminal Justice Branch, but that are not part of the evidentiary record in these proceedings.
- They did not have access to the complete evidentiary record in our proceedings, some of which differs significantly from the material they had.
- They were not subjected to cross-examination in our proceedings.

I will take those matters into account in assessing their evidence, and in determining how much weight I will attach to it. I emphasize that these are not court proceedings, and I consider it important to have these reports filed, to ensure as complete a record as possible. The problems identified above were, to some extent, addressed by providing these three experts with the reports of, and transcripts relating to, experts who did testify, whose opinions they might take issue with, and by giving them an opportunity to file supplementary opinions. Those supplementary opinions are summarized at the end of my summary of each such expert's original opinion.[217]

B. FORENSIC PATHOLOGISTS

1. Dr. Charles Lee

Dr. Charles Lee is a forensic pathologist. After obtaining a medical degree from the University of Alberta in 1994, he completed a residency in anatomic pathology in Vancouver and a forensic pathology fellowship in Albuquerque, New Mexico. He has been a member of the Forensic Pathology Department of Vancouver General Hospital since 2002, where he has completed 2,500-3,000 autopsies, most of them forensic. A forensic pathologist performs autopsies on people who have died suddenly or in suspicious circumstances, in order to determine the cause of death. I qualified Dr. Lee as an expert in forensic pathology.

Dr. Lee performed an autopsy on Mr. Dziekanski on October 16, 2007. His external examination revealed a puncture mark in the centre of the chest at the lower end of the sternum, consistent with a barb from a TASER conducted energy weapon. There was also a puncture-type scratch on the lower right abdomen at the belt level that could have been from a conducted energy weapon, although it did look different than the one on the chest. He found scratches, bruises, or abrasions consistent with an altercation or struggle and the application of handcuffs; broken ribs and breastbone; and pinpoint hemorrhages of very small capillaries (petechiae) in the lower left eyelid, all consistent with resuscitation efforts by CPR. He found no evidence of a contusion or abrasion on the neck area.

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[217] With respect to the procedures I adopted, as outlined in this section, no objection was taken by counsel for any participant, and I was not asked to call or re-call any witness.

His internal examination revealed no internal injuries, and most of the organs were relatively normal. He did a layer-wise dissection of the front of the neck, but found no evidence of any internal hemorrhaging or bleeding of any sort, saw no internal neck injuries to suggest any force being applied to the neck, and saw no signs of asphyxiation. When he was asked about the significance of one of the officer's knees being placed on the back of Mr. Dziekanski's neck, he said:

> I don't think that played a significant role since he was still struggling, he was still moving around, and he was still somewhat vocalizing, which indicates that he was still able to breathe.[218]

Overall, Mr. Dziekanski was in reasonable health. Three organs were consistent with alcohol use:

- He had a very fatty liver, which suggested recent alcohol ingestion (i.e., within a few days).
- The cerebrum and cerebellum parts of his brain were atrophied or shrunken, which was fairly specific to chronic alcohol use. The rest of the brain was relatively normal.
- There was evidence of cardiomyopathy,[219] based on the gross visual examination, although the microscopic findings were minimal and did not confirm cardiomyopathy. The lower chambers of his heart (ventricles) were markedly enlarged (dilated), and the wall of the heart was somewhat thinned. There was an absence of atherosclerosis in the coronary arteries. It was Dr. Lee's experience that many chronic alcoholics have dilated hearts and very clean coronary arteries. Overall, the heart was in reasonably good health, and the dilation was more in the nature of a "finding" than a significant potential cause of death by itself.

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[218] Transcript, April 28, 2009, p. 11.

[219] Dr. Lee defined cardiomyopathy as diseases of the heart muscle that are not associated with diseases of the coronary arteries or of the valves.

Dr. Lee told me that his microscopic examination of these organs, and the toxicology results,[220] confirmed his findings respecting the liver and brain. The autopsy and toxicology yielded a negative autopsy – there was no anatomic or toxicological cause of death. His findings respecting the three organs pointed to alcohol use, but those findings by themselves would not have killed Mr. Dziekanski. His cardiomyopathy may have increased his likelihood of having a sudden death, but it was not something that Dr. Lee considered imminent. Mr. Dziekanski was reasonably healthy.

Dr. Lee distinguished between the mechanism of death and the cause of death. In this case, Mr. Dziekanski likely developed a lethal arrhythmia, which was the mechanism of death (i.e., the physiological process by which the cause of death exerts its effect). However, in cases like this, it is very difficult to come up with an accurate and appropriate cause of death (i.e., what caused the lethal arrhythmia). In his report, he stated:

> PART 1. PRINCIPAL CAUSE OF DEATH:
>
> - Sudden Death During Restraint
>   - due to or as a consequence of ...
>
> PART 2. CONTRIBUTORY FACTORS:
>
> - Chronic Alcoholism

Dr. Lee told me that alcohol did not play a role in Mr. Dziekanski's death, because he did not have any alcohol in his body at that time. However, the changes to his organs due to chronic alcoholism could have made him more susceptible to the development of a lethal arrhythmia.

Dr. Lee emphasized that the principal cause of death was sudden death during restraint, adding:

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[220] I qualified Dr. Walter Martz, a toxicologist presently working as a senior scientist and the scientific director at the Provincial Toxicology Centre, as an expert in the area of toxicology. He testified that he analyzed blood, liver, and vitreous fluid samples taken from Mr. Dziekanski, and no alcohol, prescribed medication, or illicit drugs were detected: Transcript, April 30, 2009, p. 40ff, and Exhibit 116.

> There were at least two forms of restraint that I saw. Number 1 was a TASER, number 2 was the – I guess the tackling of the individual by the RCMP officers. Both of those forms of restraint contributed eventually to his death.[221]

He told me that there was no single cause of death. There were a number of factors that all contributed to finally causing the death. The physical interaction with the police and the conducted energy weapon both contributed to Mr. Dziekanski's death, but he could not really differentiate what proportion each played. Dr. Lee added that although the Pritchard video shows that Mr. Dziekanski was agitated, nothing in the autopsy showed a reason for him to have been delirious (e.g., drugs, alcohol, or altered mental state). He concluded his written report with the following:

> His dilated cardiomyopathy would have put him at an increased risk for development of an arrhythmia and sudden death, but probably would not have caused death by itself. The added stress of the physical restraint along with the decreased ability to breathe as a result of being pinned in the prone position may have been enough to elicit a fatal arrhythmia. The presence of signs of chronic alcohol abuse does raise a possibility that he was suffering from alcohol withdrawal, which may partly explain his agitation. It is likely a combination of these and other contributory factors that led to his death. Therefore, the cause of death is best described as sudden death following restraint.[222]

Dr. Lee agreed that "sudden death during restraint" is well-documented in the medical literature, in trying to put a name to a phenomenon that is difficult to describe, when there is no obvious anatomical cause of death. However, there are known behaviours and demographic patterns associated with this phenomenon, including: subjects who are males between 20 and 50 years of age, agitated behaviour, collapse shortly after restraint, sweating, wide eyes, irrational behaviour, and barricading.

Dr. Lee said that it would have been nice to know that the conducted energy weapon had been deployed against Mr. Dziekanski five times (not once, as he understood), although that new information would not have changed his final opinion on the cause of death. All the research he had read said that the weapon's electrical current does not affect the heart. A number of deaths have occurred in similar situations, in which a conducted energy weapon was not involved, thus it is difficult to say, had he not been hit with a TASER, whether or not Mr. Dziekanski would have lived or died. In these types of cases, the adrenergic response is believed to be the mechanism of death – i.e., the adrenaline that flows through the body whenever the body is in a stressful or dangerous situation – and pain can increase the adrenergic response. This outflowing of adrenaline increases blood pressure and heart rate, which can potentially lead to an arrhythmia.

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[221] Transcript, April 27, 2009, p. 25.

[222] Exhibit 76, p. 6.

Dr. Lee said that the evidence of Mr. Dziekanski making snoring sounds likely may have been agonal breathing, which refers to chest movements or breathing movements made by a person who is on the verge of dying, even though the heart has stopped; these chest movements could have been misinterpreted by witnesses as normal breathing. Agonal breathing can continue for a few minutes after the person has probably died. However, if the person had a pulse and the chest was seen to rise and fall five minutes after the snoring sound, it would probably indicate that it was not agonal breathing. Turning blue would probably indicate that he was not getting sufficient oxygen. It would be an indication that the person is in cardiac arrest or is close to going into cardiac arrest, and one should be prepared to do further resuscitative efforts on short notice.

Dr. Lee said that while Mr. Dziekanski's cardiomyopathy was not severe enough to cause sudden death, it may have increased his susceptibility to other stressors, such as lack of food, water, or sleep; recent cessation of smoking or alcohol consumption; and being alone at the Airport for eight or more hours.

If it was established that Mr. Dziekanski had a pulse and respiration several minutes after being handcuffed, it is unlikely that the discharge of the conducted energy weapon's electrical current directly caused an arrhythmia, since such an electrical charge should have an immediate effect on the heart, and there should be no detectable pulse within seconds.

Dr. Lee was not prepared to conclude that Mr. Dziekanski was going through alcohol withdrawal; it is difficult to make such a diagnosis in a non-hospital setting. In other respects, Dr. Lee generally agreed with those parts of the reports of Dr. Vincent Di Maio and Dr. Swerdlow that he was asked about. However, he added that it would be speculative to say that Mr. Dziekanski stopped breathing before his heart stopped beating. Dr. Lee said that acidosis cannot be detected post-mortem, especially when the autopsy is performed (as in this case) two days after the death.

2. Dr. Vincent J.M. Di Maio

Dr. Di Maio is a consultant in forensic pathology in San Antonio, Texas. He is the co-author of a book entitled *Excited Delirium Syndrome*. He was retained by the Criminal Justice Branch of the Ministry of Attorney General to prepare a report on Mr. Dziekanski's death, as part of its charge assessment process. His September 16, 2008, report was filed as an exhibit in our proceedings (Exhibit 79), although Dr. Di Maio did not testify.

After summarizing the facts based on the materials he had reviewed, Dr. Di Maio stated:

> ... it is my opinion that death was due to a cardiac arrhythmia secondary to the effects of chronic alcohol abuse; alcohol withdrawal; stress from both the emotional and physical results of the withdrawal; the struggle with law enforcement personnel and alcoholic cardiomyopathy. The mechanism precipitating the fatal arrhythmia was, in all medical probability, a hyperadrenergic state due to elevated levels of catecholamines produced by autonomic hyperactivity, psychomotor agitation, anxiety, and the struggle, superimposed on increased catecholamine levels observed in cardiomyopathies and chronic alcohol abuse.[223]

In Dr. Di Maio's view, there was no evidence that use of the conducted energy weapon caused the death. The only way the weapon could theoretically cause death directly would be by producing a fatal cardiac arrhythmia (i.e., by electrocution), and the arrhythmia produced would have to be ventricular fibrillation. But ventricular fibrillation results in unconsciousness within 5-15 seconds and cessation of respiration within a minute, neither of which occurred in this case.

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[223] Exhibit 79, p. 6.

Dr. Di Maio provided a second report on May 27, 2009 (Exhibit 190), in which he commented on the reports of several other experts:

- ***Dr. Butt*** – Dr. Di Maio said that although there were no specific cardiac lesions diagnostic of chronic alcohol abuse, Mr. Dziekanski did have atrophy of the vermis which, in his age group, is virtually the same. While Dr. Butt made mention of a respiratory component contributing to death, he did not specify what it was.
- ***Dr. Kerr*** – Dr. Di Maio said that cyanosis is secondary to inadequate oxygenation of blood, and is not specific to respiratory problems. Further, research disproves the suggestion that a conducted energy weapon causes significant acidosis or metabolic derangement.
- ***Dr. Tseng*** – Dr. Di Maio said that Dr. Tseng's opinions rely on pig experiments, but differences between pigs and humans (e.g., greater sensitivity to electricity, anesthesia can sensitize the heart, etc.) make extrapolation risky. In addition, Dr. Tseng cited no evidence for his opinion that the weapon caused ventricular tachycardia that evolved into ventricular fibrillation.

3. Dr. Michael S. Pollanen

Dr. Pollanen received his Ph.D. (1995) and his medical degree (1999) from the University of Toronto. He became a Fellow of the Royal College of Pathologists of the United Kingdom (2001) and a Fellow of the Royal College of Physicians and Surgeons of Canada in Anatomical Pathology (2003). He was appointed as the Chief Forensic Pathologist for Ontario in 2006, is an associate professor of laboratory medicine and pathobiology at the University of Toronto, and was the Founding Chair of the Forensic Pathology Section of the Canadian Association of Pathologists. He has published more than 50 papers in the peer-reviewed medical literature, including in the area of custodial death.

At the request of the Integrated Homicide Investigation Team, Dr. Pollanen prepared an independent review of the autopsy of Mr. Dziekanski, and provided an opinion on the medico-legal issues in this case. He did not testify at our evidentiary hearings.

With respect to the autopsy, Dr. Pollanen noted:

- Although Dr. Lee performed a special forensic dissection of the front of the neck, there was no indication of a dissection of the back of the neck.
- Some ancillary tests, such as histology of the "TASER mark" and vitreous electrolytes, appear not to have been performed.
- There was no discussion of the putative role of the TASER deployment.
- His review of the histology revealed a fatty liver, pulmonary hemorrhage, rare pulmonary fat emboli, and degeneration of the cerebellar vermis, but he could not confirm the presence of dilated cardiomyopathy. Thus, he did not believe that heart disease contributed to death.
- While chronic alcoholism might have contributed to Mr. Dziekanski's agitated state, perhaps by alcohol withdrawal, there is little objective evidence to support or refute that proposition.

With respect to Mr. Dziekanski's agitated state and the prone-position restraint, Dr. Pollanen stated that Mr. Dziekanski was markedly agitated and could qualify for a diagnosis of excited delirium, although two features of so-called restraint deaths associated with excited delirium were absent – a documented major psychiatric illness (e.g., schizophrenia or bipolar disorder) and acute intoxication with cocaine or a similar stimulant drug. The video evidence clearly demonstrates prone-position restraint, but Dr. Pollanen added:

> However, there is no reliable evidence of major chest compression that could cause direct interference with breathing. On this basis, it seems clear that a direct "asphyxia" death from restricted breathing can be excluded. But, I am unable to exclude that the prone-positioning contributed to a relative reduction in ventilation to meet the increased oxygen requirements of an agitated state (e.g., increased oxygen demands due to physical exertion).[224]

With respect to the effects of the conducted energy weapon, Dr. Pollanen concluded that the video evidence of Mr. Dziekanski's activities after deployment of the weapon clearly excluded a direct weapon-related acute arrhythmic death. He then turned to whether the weapon could have been a co-factor in the death, which had two dimensions:

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[224] Exhibit 80, p. 11.

- The death could be explained entirely by the excited delirium/prone-position restraint concept, without referring to additional causes. It is a fact that most people who die in this situation are not subject to a conducted energy weapon deployment, so it is possible to conclude that the weapon need not be a factor in the death.
- If the excited delirium/prone-position restraint concept is accepted as an explanation for the death, then any co-factor that increases agitation or induces additional stress should exacerbate the mechanisms leading to death. Thus, the weapon could have contributed to the death through a non-arrhythmogenic mechanism. He stated:

> Although the data is conflicting, I have an open mind to the possibility that the TASER discharge may have indirectly contributed to death through a non-arrhythmogenic mechanism. A simple line of reasoning supports this conclusion. If a theory is developed to explain death based on excited delirium or an agitated state, it seems difficult to argue (based on the video) that Robert Dziekanski was not more (dis)stressed or agitated after the deployment of the TASER. However, to be entirely balanced on this point, knowledge is evolving, both in the area of excited delirium and the physiologic effects of the TASER (e.g., dose-dependency of metabolic effects, species differences in TASER responses, lack of a suitable animal model of excited delirium that can be studied using TASER discharges).[225]

Dr. Pollanen concluded that Mr. Dziekanski did not die of a conducted energy weapon-induced cardiac arrhythmia, or from a physical injury, the toxic effects of a drug, or an acutely fatal natural disease or condition. He added that if Mr. Dziekanski's death was caused, in part, by the adverse effects of an agitated state, then we need to keep an open mind about the putative role that the conducted energy weapon may have played in indirectly contributing to death, since he appeared more stressed or distressed and agitated after the deployment of the weapon.

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225 Exhibit 80, pp. 11-12.

4. Dr. John Butt

Dr. Butt has a medical degree from the University of Alberta (1960), a Licentiate of the Medical Council of Canada (1962), a Diploma of Medical Jurisprudence (London, England, 1969), and is a Fellow of the Royal College of Pathologists (Great Britain, 1985). He was the Chief Coroner of Alberta, following which he developed the Medical Examiner System in Alberta and became that province's first Chief Medical Examiner (1993). He became the Chief Medical Examiner for Nova Scotia (1996), and served as clinical professor of pathology at Dalhousie University in 1999. He now has a consulting practice in forensic pathology. I qualified him as an expert in the field of forensic pathology and cause of death.

The Commission asked Dr. Butt to review Dr. Lee's autopsy report, and to comment on the expert reports of Drs. Pollanen and Di Maio. In his April 17, 2009, report he did so as follows:

- ***Dr. Lee*** – Mr. Dziekanski's principal cause of death (sudden death during restraint) relates to circumstances alone, and is not a medical diagnosis. However, Dr. Lee's comments on circumstances were not complete, in that there was no mention of the deployment of the conducted energy weapon. In Dr. Butt's experience, it would be uncommon for the pathologist who performed the autopsy not to discuss the role of the weapon, given the circumstances of Mr. Dziekanski's death. In addition, Dr. Butt stated that after finding the microscopic slides of sections of Mr. Dziekanski's heart to be essentially normal, he was unable to conclude that the features that he saw represented alcoholic cardiomyopathy.
- ***Dr. Pollanen*** – Dr. Butt was generally in accord with Dr. Pollanen's opinions, although he added that caution is advisable about use of the term "excited delirium," which is questioned by those practising psychiatry.
- ***Dr. Di Maio*** – his opinion that Mr. Dzekanski was in a state of excited delirium just before the conducted energy weapon was deployed led Dr. Butt to respond that pathologists do not commonly have the experience to make clinical diagnoses about aberrant behaviour, such as delirium. Further, Dr. Di Maio appears to have reiterated Dr. Lee's conclusions about the heart (without having reviewed the microscopic slides himself) but nevertheless offered his opinion about the

> pathophysiology of alcoholic cardiomyopathy, including fatal arrhythmia of the heart related to cardiomyopathy and chronic alcohol abuse.

Dr. Butt stated that he did not find evidence, in examining microscopic sections of the heart, to conclude that Mr. Dziekanski had alcoholic cardiomyopathy. From his review of the videos showing Mr. Dziekanski walking around in the Customs Hall, he saw nothing to indicate that he was unsteady on his feet (i.e., that he was ataxic), which is usually the case with cerebellar degeneration. He concluded:

> Robert Dziekanski's cause of death was *likely* related to his heart, and somehow to nerve conduction pathways in his heart and an arrhythmia. Given this, I believe that increasing exertion and stress seen following the discharge of the CEW (TASER) likely contributed to the death of Robert Dziekanski. As well the death may have had a respiratory component through restriction of air into the air passages/lungs. I do not believe that there was enough pathological evidence in the autopsy of Robert Dziekanski to be sure of the medical cause of death.[226]

In his testimony, Dr. Butt said that, based on the weight of Mr. Dziekanski's heart and the thickness of the walls of the two ventricles, he did not think that the chambers were dilated. He examined eight microscopic slides of the heart and found no significant myocardial or interstitial change, from which he concluded that Mr. Dziekanski did not have cardiomyopathy. There was nothing about his heart that put him at increased risk of a sudden cardiac event without any other contributing factors. He agreed with the suggestion that Mr. Dziekanski's state of agitation, the fact that the conducted energy weapon had been deployed against him, being wrestled with and struggling on the ground were all triggering causes of death in the sense that they increased his heart and respiration rates, adding to his stress and causing the release of adrenaline. Left to his own devices (i.e., if the weapon had not been used and he had not been restrained on the floor), Mr. Dziekanski would have survived.

Dr. Butt said that one of the officers placing his knee on Mr. Dziekanski's upper back, as shown in the video evidence, might have reduced air entry into his lungs. Evidence

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226 Exhibit 111, p. 5.

that he turned blue indicated that there was a problem with Mr. Dziekanski's circulating oxygen, because either the respiratory or cardiovascular system was compromised. He was not prepared to say that Mr. Dziekanski's snoring-like sounds were agonal breathing.

Dr. Butt agreed that increased blood pressure would put a person at risk of a lethal arrhythmia if they were subjected to enough physical and emotional stress, although his understanding from Mr. Dziekanski's Polish medical records was that he had borderline high blood pressure.

Dr. Butt said that after he delivered his report to the Commission on April 14, 2009, he received a phone call from Commission Counsel noting that he had commented in his report on Dr. Lee's failure to discuss whether the conducted energy weapon had played any role in the death, but that he (Dr. Butt) had not reached any conclusion respecting the conducted energy weapon in his report either. Commission Counsel also sent to him a copy of a 12-page document entitled "Robert Dziekanski – Circumstances."[227] Dr. Butt reviewed that document and then submitted a revised report dated April 17, 2009, which included a new statement: "Given this, I believe that increasing exertion and stress seen following the discharge of the CEW (TASER) likely contributed to the death of Robert Dziekanski." He testified that he continued to be of the view that it is likely that the conducted energy weapon contributed to Mr. Dziekanski's death, directly or indirectly.

He also testified that it is generally agreed that there is no support in any peer-reviewed medical literature for the concept of delayed ventricular fibrillation from an electrical cause.

Dr. Butt said that he had no issue with Dr. Lee about Mr. Dziekanski's chronic alcoholism. The question was whether it was actually a contributing factor to the death.

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[227] See Exhibit 105. This document, prepared by the Commission and provided to persons who would be giving expert evidence, was a summary of Mr. Dziekanski's movements on October 13 and 14, 2007, drawn from the evidentiary record.

Dr. Butt was referred to his conclusion that death may have had a respiratory component through restriction of air into the air passages/lungs. He agreed that this opinion is inconsistent with the evidence of Mr. Enchelmaier. He also agreed that there was no objective evidence to back up the position that the officers caused the death as a result of the struggle.

C. CARDIOLOGISTS

1. Dr. Charles Swerdlow

Dr. Swerdlow received his M.D. from the Harvard-MIT Program in Health Sciences and Technology, completed his internship and residency in medicine at the Los Angeles County-UCLA Harbor General Hospital and completed a fellowship in cardiology at the Stanford University Medical Center. He is board certified in internal medicine, cardiology, and clinical cardiac electrophysiology. He is currently a clinical professor of medicine at UCLA and attending physician in the Cardiac Electrophysiology Laboratory at Los Angeles' Cedars-Sinai Medical Center. I accepted him as an expert in cardiology and electrophysiology.

In his written report,[228] Dr. Swerdlow stated that the mechanism of cardiac arrest caused by cardiac electrical stimulation lasting less than 15 seconds is almost always ventricular fibrillation, which results in abrupt failure of the heart to pump blood and characteristically causes loss of consciousness within about 10 seconds. Much less frequently, the rhythm is ventricular tachycardia. Two other classes of cardiac rhythms that may be recorded during cardiac arrests, due to causes other than ventricular fibrillation, are:

- Pulseless electrical activity (a regular cardiac rhythm is present, but the heart is not pumping blood); and
- Extreme bradycardia (the heart generates impulses at a rate too low to sustain life), or asystole (the heart stops generating electrical impulses). Asystole, which was recorded in Mr. Dziekanski's case, may

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[228] See Exhibit 104.

> occur in cardiac arrests caused by heart disease or those secondary to respiratory arrests, neurological events, delirium, metabolic effects, or drug effects (including cocaine).

If collapse is delayed, or the initial post-arrest rhythm is not ventricular fibrillation, then the mechanism of death is not electrically induced ventricular fibrillation. In the case of Mr. Dziekanski, the detailed report of a normal pulse for minutes after the conducted energy weapon discharge and the initial cardiac arrest rhythm of asystole excludes electrically induced cardiac arrest related to weapon discharge.

With respect to sudden in-custody deaths, Dr. Swerdlow's research confirms that subjects who die of non-traumatic sudden deaths after the discharge of a conducted energy weapon have demographic and drug-use profiles similar to those in prior reports of sudden deaths during law enforcement interactions that were unassociated with the use of conducted energy weapons. His research also shows that the initial cardiac rhythm in sudden death temporally proximate to the use of a conducted energy weapon is pulseless electrical activity or asystole in over 90 percent of cases in which it can be determined. This excludes the diagnosis of electrically induced cardiac arrest in these cases.

Small studies have reported fatal asystole caused by metabolic acidosis after struggles that did not involve conducted energy weapons, although the precise mechanisms by which acidosis causes cardiac arrest are not understood with certainty. It is known that conducted energy weapon discharges cause nerve-mediated muscular contractions that produce lactic acid, but studies of human volunteers found that discharges of 5-20 seconds result in a minor, transient reduction in pH that is not clinically significant. Several studies concluded that probe-mode discharges cause less acidosis than vigorous exercise, and the effect peaks within one minute of discharge and dissipates rapidly.

Dr. Swerdlow agreed that his analysis relies on a statement of assumed facts prepared by the Commission and his review of the testimony of Mr. Enchelmaier. He concluded that, because Mr. Enchelmaier identified a pulse about two minutes before the arrival of the firefighters, the best evidence is that Mr. Dziekanski did not develop cardiac arrest until 9-11 minutes after the last discharge of the conducted energy weapon. This excludes electrically induced ventricular fibrillation. Further, the two defibrillators used by the paramedics showed that the initial cardiac rhythm was asystole, excluding the diagnosis of ventricular tachycardia or ventricular fibrillation.

Dr. Swerdlow concluded that several factors probably contributed to Mr. Dziekanski's cardiac arrest: respiratory acidosis and possibly respiratory arrest, possible metabolic acidosis, and underlying alcoholic cardiomyopathy.

Mr. Dziekanski had several characteristics typical of subjects who experienced sudden in-custody deaths – male gender, aged 20-50, agitated behaviour, collapse shortly after restraint, asystole. However, he was atypical in that he did not have a history of stimulant drug use or mental illness.

He concluded that in most cases the pathophysiological mechanism responsible for sudden in-custody deaths is unknown, and no known electrophysiological effect of conducted energy weapon stimulation can cause death as it occurred in Mr. Dziekanski's case.

In his testimony, Dr. Swerdlow explained that it was exceedingly unlikely that Mr. Dziekanski went into ventricular fibrillation prior to the asystole that was found by the firefighters and paramedics. Based on Mr. Enchelmaier's testimony that Mr. Dziekanski had a pulse two minutes before the arrival of the firefighters, it is highly unlikely that he went into ventricular fibrillation after Mr. Enchelmaier's last pulse check, and that the ventricular fibrillation changed into asystole before the firefighters found Mr. Dziekanski to be pulseless two to three minutes later. In any event, if ventricular fibrillation occurred about nine minutes after the last conducted energy weapon deployment, the weapon's electrical current could not have caused it, because when such electrical stimulation causes rhythm disturbance, it happens immediately.

Dr. Swerdlow discounted the significance of the evidence that Mr. Dziekanski became cyanotic within a minute of being handcuffed:

> But whether or not he was turning cyanotic because he wasn't breathing, we still have good evidence that he had a strong and, for practical purposes, relatively close to normal pulse for a number of minutes.[229]

Dr. Swerdlow doubted that the evidence of Mr. Dziekanski making snoring sounds was agonal breathing, given the other evidence of his continued shallow breathing up until shortly before the arrival of the firefighters.

With respect to indirect effects of a conducted energy weapon, Dr. Swerdlow said that both sympathetic nervous stimulation and stress-related hormones (catecholamines) could directly affect the heart. They can make the heart beat faster, and in vulnerable individuals they can cause ventricular tachycardia and fibrillation, which typically occurs within a few seconds or a minute. However, in Mr. Dziekanski's case, he had a normal rhythm for minutes later. Dr. Swerdlow added:

> And so while I think it's nearly certain Mr. Dziekanski was stressed, there's no evidence that stress, whether it was the stress of the confrontation, stress of fighting with the police officers, or any other kinds of stress he was under or stress from the TASER – whatever the stress he was under, it didn't cause the cardiac arrhythmia that led to his death.

Dr. Swerdlow said that there are two types of acidosis that might be applicable in this case. The first is respiratory acidosis. If a person stops breathing, the body is unable to exhale built-up carbon dioxide that has resulted from metabolic activity. The carbon dioxide builds up in the blood as carbonic acid, and cellular mechanisms, including cardiac contraction, work less well, and the subject can die. The second is metabolic acidosis. Lactic acid is generated when muscles work very hard and do not get sufficient oxygen transported to them. Normally a body gets rid of lactic acid by transporting it to the liver, where it is converted into carbonic acid, which is the acid that the lungs can then breathe out as carbon dioxide. However, if the person has liver disease, it will take longer for the liver to convert the lactic acid to carbonic acid. In addition, if the person is not breathing well, the potential for being acidotic is greater.

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[229] Transcript, April 28, 2009, p. 36.

On May 26, 2009, Dr. Swerdlow provided a second written opinion, responding to the reports of Drs. Tseng and Kerr, in which he discussed two issues. First, with respect to the likelihood of weapon-induced ventricular tachycardia, he said that Dr. Tseng's hypothesis that the weapon induced hemodynamically stable ventricular tachycardia, which degenerated into ventricular fibrillation and then asystole, is dependent on the existence of five conditions:

- Both of the weapon's probe electrodes had to be located on the anterior chest, but the evidence is that the lower probe was attached to Mr. Dziekanski's shirt, adjacent to his abdomen.
- Mr. Enchelmaier's report of Mr. Dziekanski's pulse must be disregarded, but in Dr. Swerdlow's opinion, Mr. Enchelmaier's account was highly credible. In his experience, significant pulsus alternans is uncommon during ventricular tachycardia.
- The weapon discharge must have induced a ventricular tachycardia that was sustained and remained hemodynamically stable for over seven minutes. This was not recorded in Mr. Dziekanski's case, and has never been recorded after any conducted energy weapon discharge in animals or humans.
- The postulated ventricular fibrillation, which was never recorded, had to degenerate into asystole within the remaining portion of the three to four minutes. However, there is no evidence of either ventricular tachycardia or ventricular fibrillation, and the hypothecated degeneration into asystole over an atypically short interval is contrary to animal studies.
- Mr. Dziekanski would be the first person who collapsed more than a minute after weapon discharge to have ventricular tachycardia as an initial rhythm. However, in this case all the evidence points to an asystolic cardiac arrest. No evidence points to undetected ventricular tachycardia or fibrillation, and Dr. Swerdlow's own study of unexplained sudden deaths found no instance of ventricular tachycardia as the initial cardiac arrest rhythm.

Dr. Swerdlow also disagreed with Dr. Tseng's hypothesis that a conducted energy weapon discharge delivered over the abdomen can induce ventricular tachycardia and cardiac arrest. They have never been reported to induce any sustained cardiac rhythm disturbance in animals or humans, and in his view Dr. Tseng's recent study of in-custody deaths in 50 California cities found no significant statistical association between sudden death and weapon deployment.

Second, with respect to the likelihood that indirect effects of weapon discharge contributed significantly to death, Dr. Swerdlow agreed with Dr. Kerr that Mr. Dziekanski likely had respiratory acidosis from reduced ventilation and lactic acidosis from exertion during the struggle, possibly combined with limited ability of his abnormal liver to metabolize lactate. However, recent studies of exhausted human volunteers who then received a 15-second weapon discharge found no increase in acidosis and only a modest increase in lactate. Other studies have shown that conducted energy weapons do not impair respiration. With respect to a hyperadrenergic state, Dr. Swerdlow agreed that any stressful situation can increase sympathetic nervous system activity, and it is reasonable to assume that a physical confrontation with law enforcement may produce a hyperadrenergic state. He added:

> Thus, it is reasonable to postulate that Mr. Dziekanski had a hyperadrenergic state during his confrontation with the RCMP and that he may have had a hyperadrenergic state before this confrontation. But neither postulate can be proved. It is not possible to determine the relative contributions of the CEW discharge and other factors to the postulated hyperadrenergic state; it is not possible to determine the relationship between the postulated hyperadrenergic state and mechanism of death.[230]

2. Dr. Charles Kerr

Dr. Kerr received his medical degree from the University of British Columbia (1973), followed by a residency in cardiology and a fellowship in electrophysiology. He is a staff cardiologist and electrophysiologist at St. Paul's Hospital in Vancouver and a professor at the University of British Columbia. I accepted him as an expert in cardiology and electrophysiology.

Dr. Kerr explained that electrophysiology is the study and practice of treating patients who have abnormalities of the electrical system of the heart. The electrical system has a built-in pacemaker (the sinus node), which triggers very uniform and sequential electrical flows through the heart, providing a rhythmic and fluid contraction pattern. Superimposed on that is the autonomic (i.e., subconscious) nervous system of the heart, which consists of the sympathetic nervous system and the parasympathetic nervous system. The former tries to speed up the heart, while the latter tries to slow it down.

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[230] Exhibit 185, p. 11.

In situations of stress (or even physical activity), there is a sudden surge of the sympathetic nervous system, which is activated in two ways:

- There is a direct connection from the brain through the sympathetic nerve fibres that go right into the heart muscle and stimulate the various parts of the electrical system of the heart.
- In a fight-or-flight situation, the brain stimulation results in adrenaline surging directly down the sympathetic nervous system. In addition, hormones in the bloodstream (i.e., catecholamines) act on those nerve fibres in the heart and directly on the cells of the heart. In a situation where you get very intense stimulation, the adrenergic state gets progressively higher and starts to push the heart to tremendous degrees.

Dr. Kerr said that when the person has high adrenaline levels, the heart is much more prone to developing various types of abnormal rhythms. Cells that do not normally drive the heart can start firing off extra beats. This can actually change the electrical system of the heart, creating the possibility of abnormal rhythms developing where electricity will chase itself around in circles around structures in the heart and cause, potentially, more sustained arrhythmias. Although this kind of rhythm is most commonly benign, it becomes worrisome if the person has a susceptibility to other factors, such as metabolic derangements. The heart can become so irritable that it can develop a more sustained abnormal rhythm, which, if it comes from the lower chamber of the heart, can be a very serious and life-threatening arrhythmia – ventricular tachycardia or ventricular fibrillation. Adrenaline surges brought on by physical exertion or stress are very unlikely to bring on ventricular arrhythmia unless there is also an underlying heart disease.

Dr. Kerr said that based on the material he had reviewed, Mr. Dziekanski's heart weight was normal, and his blood pressure was normal or possibly borderline. He may have had a slightly dilated heart, but that could have been from the physical exertion at the Airport. He may have had a very mild cardiomyopathy, but certainly not advanced cardiomyopathy. It would have been highly abnormal for someone without quite significant structural heart disease to have an unprovoked episode of ventricular arrhythmia. He was asked about the statement in his written report that the intense pain resulting from multiple TASER applications would have sent surges of catecholamines into his circulation and stimulated the nerve fibres, exacerbating the pre-existing hyperadrenergic state. He responded:

> I've read quite a bit about TASER applications and ... they're obviously intensely painful. So one is getting an intensely painful stimulation, which we know, again, causes an intense outpouring of the sympathetic nervous system, both the releasing of more adrenaline and the stimulation of the nerve fibres that go to the heart. So it's taking – an individual must have had a high – high sympathetic adrenergic state to begin with, and then applying repeated painful stimuli I think can't help but having further increased that catecholamine state.[231]

In his report, Dr. Kerr expressed the belief that it is hard to escape the conclusion that the conducted energy weapon applications contributed as a major cause of Mr. Dziekanski's death, certainly through metabolic effects and development of a hyperadrenergic state, but not excluding a direct induction of a ventricular arrhythmia by the weapon application. In his testimony he added:

> There would be no question that the level of sympathetic stimulation in this circumstance would have been astronomically high. You know, I can't think of too many situations where there would be higher sort of stimulation than in this type of a situation. Not only with respect to heart rhythms, but the high sympathetic tone stimulates all parts of the body. It will also stimulate the heart to beat excessively rapidly.[232]

Dr. Kerr said that in addition, Mr. Dziekanski became hypoxic (i.e., low oxygen levels in the blood), which would make the heart more prone to electrical development by weakening the heart muscle, further decreasing the circulation, further enhancing the release of lactic acid, leading to a downward spiral in how the heart would be functioning. It is theoretically possible that the heart could get so tired that it just stops working, if you had a very high sympathetic level.

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[231] Transcript, May 7, 2009, pp. 83-84.

[232] Transcript, May 7, 2009, p. 86.

In his written report, Dr. Kerr stated that it is logical and highly probable that Mr. Dziekanski developed a fast, abnormal rhythm from his ventricle sometime after the conducted energy weapon application and before the time he was noted to be cyanotic and not breathing. He added:

> With respect to the role of TASER discharge in Mr. Dziekanski's death, there are two principal possibilities. First, it is possible that the TASER profoundly exacerbated his hyperadrenergic state, led to acidosis and general severe metabolic derangement, and thereby, created a milieu where spontaneous malignant arrhythmias could arise. Secondly, there remains a possibility that the TASER discharge could have directly induced ventricular arrhythmias, given that a TASER barb appeared to be on the anterior chest, quite close to the heart. It is unlikely that TASER discharges directly induced ventricular fibrillation, as this would have caused much more rapid loss of consciousness. However, they could have induced ventricular tachycardia that subsequently contributed to loss of adequate circulation, transition to ventricular fibrillation, then asystole and death. Therefore, I believe that there is a very high probability that the multiple TASER applications were instrumental in the development of malignant ventricular arrhythmias and death.[233]

Dr. Kerr agreed that if Mr. Enchelmaier's monitoring of Mr. Dziekanski's pulse and breathing were accurate, that would rule out that Mr. Dziekanski was in a state of ventricular tachycardia during the period up to and including his last monitoring.

3. Dr. Zian Tseng

Dr. Tseng has a bachelor's degree in biochemistry and molecular biology from the University of California at Berkeley, followed by a combined medical degree and Ph.D. from the University of California at San Francisco. He completed a residency in internal medicine, a fellowship in cardiology, a fellowship in electrophysiology, and a master's degree in clinical research and epidemiology, all from the University of California at San Francisco. He is an assistant professor of medicine in the Cardiac

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[233] Exhibit 129, p. 3.

Electrophysiology Section of that institution. I qualified him as an expert in cardiology and electrophysiology.

In his written report (Exhibit 135), Dr. Tseng noted that Dr. Lee had found a dark punctuate abrasion on the central chest that was consistent with a conducted energy weapon electrode. He found several other punctuate abrasions, one on the chest and the other on the abdomen. If the one on the chest represents the second barb mark, then the probe-mode discharges were delivered over the cardiac axis with probe penetration, which resulted in direct cardiac capture and induction of sustained ventricular tachycardia.

Alternatively, if the second barb attached to the abdomen, then the vector was not over the cardiac axis and the weapon's discharges did not directly induce ventricular tachycardia by cardiac capture. However, the adverse physiological effects, including stress, pain, and adrenaline surge, resulting from the weapon discharges, triggered a sustained ventricular tachycardia. Due to alcoholic cardiomyopathy, Mr. Dziekanski's cardiac function was already compromised, and ventricular tachycardia eventually resulted in hemodynamic instability and collapse, followed by degeneration to ventricular fibrillation and asystole.

According to Dr. Tseng, this sequence of events is consistent with the evidence that Mr. Dziekanski struggled for about 90 seconds after the first weapon discharge:

> In situations of stress and high levels of circulating adrenaline, subjects are able to maintain an adequate blood pressure for several minutes, even in the setting of ventricular tachycardia and alcoholic cardiomyopathy. However, the low cardiac output due to ventricular tachycardia eventually results in a blood pressure too low to maintain consciousness or blood flow to the brain or vital organs. Thus, at this point Mr. Dziekanski became unconscious and unresponsive and was handcuffed.[234]

Dr. Tseng questioned the accuracy of Mr. Enchelmaier's testimony for several reasons:

- Although his first assessment of pulse was "strong and fast," he had not felt Mr. Dziekanski's pulse before the incident and consequently could not compare what he felt with his normal pulse. Dr. Tseng concluded that the pulse was very likely weaker than during normal rhythm – this would correlate with a low cardiac output, and would be consistent with his being unconscious, unresponsive, and cyanotic. The fast rate would correlate with it being in ventricular tachycardia.

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[234] Exhibit 135, p. 3.

- A British study found that an anesthesiologist assessed the presence of a carotid pulse in patients who were in shock and had very low systolic blood pressures (between 35 and 55 mmHg). Thus, Mr. Enchelmaier's observations are consistent with the low cardiac output resulting from a rapid ventricular tachycardia.
- Mr. Enchelmaier described a slower pulse during his second and third assessments. However, heart failure and ventricular tachycardia are two important causes of pulsus alternans, a condition Dr. Tseng had observed on many occasions where electrical rhythm results in alternating strong and weak pulses. Consequently, Mr. Enchelmaier described a slower pulse because he felt only every second pulse (i.e., only half of what the actual tachycardia rate was). Alternatively, Mr. Enchelmaier may have been feeling his own pulse – Dr. Tseng had made that mistake himself several times in Code situations.

Dr. Tseng wrote that low cardiac output due to ventricular tachycardia in the setting of alcoholic cardiomyopathy continues to the point where the heart itself receives too little blood flow, and ventricular tachycardia degenerates into ventricular fibrillation which, when untreated, almost universally results in asystole and death. In the three-and-a-half minutes between Mr. Enchelmaier's last assessment and the paramedics' reading of "no shock advised" (i.e., asystole) on the automated external defibrillator, Mr. Dziekanski's rhythm had degenerated from ventricular tachycardia to ventricular fibrillation to asystole.

Dr. Tseng also expressed the opinion that without exposure to the conducted energy weapon discharges, Mr. Dziekanski would very likely not have experienced sudden death. Without a trigger of intense pain and adrenaline release, he would not have had this ventricular arrhythmia leading to sudden death. He acknowledged that Mr. Dziekanski had experienced numerous stressors before, during, and after his flights, and was asked whether he was, as a result, at significant risk of having a heart problem even before the police arrived at the Airport:

A	No, I wouldn't say significant risk. I'd say he was at some risk, but I wouldn't quantify it as a significant risk.
Q	Well, is he at the point where he's at a risk where just about anything more added to that was going to put him into the significant risk category?
A	Yes.[235]

In cross-examination, Dr. Tseng agreed that sudden death during restraint is a known and documented phenomenon in the medical literature, and it overlaps with the phenomenon of excited delirium. It typically involves collapse shortly after restraint, agitated behaviour, sweating, pacing, barricading oneself, and minimal findings on autopsy. Commonly the first reported cardiac rhythm is either asystole or pulseless electrical activity, although such documentation is typically many minutes after the initial event. He agreed with Dr. Lee that the term sudden death during restraint is principally descriptive – trying to put a name to a phenomenon that is difficult to describe.

Dr. Tseng agreed that the mechanism of the fatal collapse of TASER-related deaths is an unanswered question and that, without the mechanism of death being known, it is only speculation to give an opinion on what caused or contributed to death in a TASER-related case. He cited several studies (by Dr. Ho, Dr. Kim, and Dr. Swerdlow) suggesting that TASER deployment has a physiological effect that causes or contributes to death. He said that his own recent research supports his view that in the case of subjects in delirium and an agitated state who then die, the risk of death is increased when a conducted energy weapon was involved. His study found that in 50 California cities, there was a six-fold increase in arrest-related deaths in the first year following introduction of conducted energy weapons. He acknowledged that thereafter the death rate returned to a statistically comparable rate.

Dr. Tseng said that the location of the punctate abrasion on Mr. Dziekanski's central chest, as shown in the photograph (Exhibit 87), is very consistent with where a cardiologist would perform a pericardiocentesis tap of the heart. If this was in fact the location of one of the weapon's barbed probes, then any other location for the other barbed probe would constitute a cardiac axis that could result in capture of the heart. His interpretation of the evidence was that the barbed probe did penetrate to sufficient depth to cause a direct cardiac capture and ventricular arrhythmia. He was referred to the statement in his report that the vector of TASER electrodes over the cardiac axis was critical for cardiac capture and induction of sustained (i.e., over 30 seconds) ventricular tachycardia in animal studies, but he acknowledged that the studies he had cited for this proposition did not show *sustained* ventricular tachycardia.

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[235] Transcript, May 8, 2009, p. 30.

Dr. Tseng agreed that there is no support in any peer-reviewed medical literature with respect to humans for the concept of delayed ventricular fibrillation caused from an external electrical source. He agreed that there are several theories of how sudden death during restraint arises, including the following:

- Stress has a physiological effect on the brain, which causes the person to stop breathing, causing the heart to stop.
- Stress from a heightened adrenergic state causes an arrhythmia of the heart.

Dr. Tseng was asked what effect pain from the weapon might have, and he responded:

> Q ... Are you saying that any pain from the TASER would cause adrenaline, acid, heart, leading to death?
> A It would be contributory. Certainly it's speculation whether or not every single TASER deployment would cause an arrhythmia, but I think it's a fair statement to say that any deployment of the TASER, whether in stun or in probe-mode, would create intense pain, and that intense pain itself would lead to an increased adrenaline state.
>
> Q And tell me something, would any other type of intense pain cause the same problems?
> A I'm not aware of any other modes of restraint that would cause such an intense response as a TASER discharge.[236]

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[236] Transcript, May 8, 2009, p. 117.

D. EMERGENCY DEPARTMENT PHYSICIANS

1. Dr. Christian Sloane

Dr. Sloane is a medical doctor, and certified by the American Board of Emergency Physicians. He is employed full time as an academic attending and assistant clinical professor at the University of California at San Diego Medical Center. He has cared for numerous patients in various states related to alcohol, including alcohol intoxication, as well as the complete range of alcohol withdrawal – from mild tremors to fully developed major alcohol withdrawal, as well as delirium tremens.

In August 2008 Dr. Sloane wrote an opinion (Exhibit 78) for the Integrated Homicide Investigation Team respecting the possible role of alcohol withdrawal as it may pertain to contributing to the death of Mr. Dziekanski. He did not testify at our evidentiary hearings. Based on his review of materials provided to him, he reached several opinions, including the following:

- The findings on autopsy (fatty liver, enlargement of the heart, cerebellar atrophy) are all well-known to occur in the setting of alcohol abuse, and it appears that Mr. Dziekanski had sustained systemic effects to his organs as a result of chronic alcohol use.
- On the Pritchard video Mr. Dziekanski is alert, but confused and sweaty. He appears to be a man in a state of agitated delirium, which could be consistent with, or exacerbated by, a state of alcohol withdrawal, though clearly not delirium tremens. In this state, one would expect him to be in a state of adrenergic excess, which could increase the likelihood of him suffering from the sudden in-custody death syndrome.
- Minor alcohol withdrawal occurs as early as six hours and usually peaks at 24 to 36 hours after cessation of or significant decrease in alcohol intake. It is characterized by mild autonomic hyperactivity: nausea, anorexia, coarse tremors, tachycardia, hypertension, hyperreflexia, sleep disturbance, and anxiety. Mr. Dziekanski's condition on that evening could certainly be consistent with some degree of alcohol withdrawal. Whether the condition of alcohol withdrawal should be added to the milieu of agitated delirium that is witnessed on the video and described by those involved, or if it is solely due to alcohol withdrawal, is difficult to definitively determine, but placed him at risk for sudden death.

- While the circumstances of Mr. Dziekanski's death are unfortunate, they are not that unique or surprising when one looks at cases of sudden in-custody death. It is often the matter that in these cases, no definitive cause of death is ever determined.

2. Dr. Jeffrey Ho[237]

Dr. Ho graduated from the Loma Linda University School of Medicine, California, in 1992. He completed his residency in emergency medicine (1995) and his fellowship in emergency medical services/prehospital care (1996) at the Hennepin County Medical Center in Minneapolis, Minnesota. He is currently Attending Faculty, Emergency Medicine, at the Hennepin County Medical Center (Level 1 Trauma Center) and an associate professor of emergency medicine at the University of Minnesota School of Medicine. He is also a deputy sheriff in the Meeker County Sheriff's Office. His area of expertise includes research into sudden and unexpected death in law enforcement custody and the physiologic effects of conducted energy weapons, and he is the author of numerous peer-reviewed papers on these subjects. I qualified him as an expert in emergency medicine and TASER research.

In his written report, Dr. Ho stated, "[I]n general, there is nothing that exists to date scientifically to support a causal connection between ECD (electronic control device) application in humans and sudden, unexpected death."[238] There are, however, general conditions that are strongly associated as risk factors in sudden death, such as underlying cardiac disease issues (e.g., dilated cardiomyopathy, as in this case) and volitional resistance during attempts at control and restraint.

Dr. Ho cautioned against using inappropriate logic when examining allegations of a possible association between conducted energy weapons and sudden deaths, such as:

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[237] Dr. Ho disclosed that he is an independent, expert medical consultant to TASER International, Inc. He owns shares in TASER, provides consultative advice to TASER upon request for which he received, in 2008, compensation totaling $61,000. He has also received remuneration from TASER for his testimony or his giving of depositions in six court cases (plus this Commission of Inquiry) on behalf of TASER.

[238] Exhibit 141A, p. 9.

- ***post hoc, ergo propter hoc*** – just because Mr. Dziekanski's death was proximate in time to deployment of the conducted energy weapon does not establish a causal relationship, and
- **causal oversimplification** – assigning causal blame to the conducted energy weapon while disregarding Mr. Dziekanski's underlying physical condition and his decision to resist, fight with, and attempt to flee from law enforcement officers.

Dr. Ho said that from a scientific standpoint, higher voltage with very low amperage is not known to be dangerous to humans, and the average delivered current of a TASER X26 is only 0.0021 amperes, compared to 16 amperes of sustained current in a typical residential wall outlet. Similarly, emergency external cardiac defibrillators typically deliver electrical energy in the range of 150-360 joules, while a TASER X26 delivers about 0.1 joule. He added that there is now a plethora of human data showing that human exposures to conducted energy weapons do not yield findings of cardiac abnormality, as measured by serum biomarkers, electrocardiograms, and echocardiography.

He stated that several recent human studies have shown that from a human physiology standpoint, no harm has been found to be associated with a conducted energy weapon exposure when used in probe or push-stun mode, and even when the application was directly over the heart. He cautioned against extrapolating the results from swine studies to humans. Further, the manufacturer has documented no complaints of death after more than 680,000 voluntary human exposures, which is a vastly larger number of study subjects than required before approval of a medical device or therapeutic drug.

Dr. Ho said that Mr. Dziekanski's underlying condition of metabolic acidosis should not be underestimated. This condition is known to be an associated risk for a sudden death event that is independent of the application of a conducted energy weapon. At the same time, there is no evidence that the weapon caused ventricular fibrillation, which is generally known to be relatively instantaneous. However, Mr. Dziekanski's changing pulse rates as described are quite consistent with those that are due to extreme acidosis states induced by agitated and continued resistive behaviour, and this mechanism of death is independent of the application of a conducted energy weapon. He agreed with Dr. Lee that Mr. Dziekanski's sudden death during restraint

> ... was likely due to a variety of factors including his underlying disease processes secondary to alcohol abuse and his volitionally elevated state of metabolic demand. It is my opinion that [Mr. Dziekanski's] death was most likely due to a terminal arrhythmic event brought about by the stress of his elective physical resistance and from his underlying cardiomyopathic condition that was brought about by his alcohol abuse. [Mr. Dziekanski] represents a person with multiple factors associated with [sudden death] (gender, [body mass index], underlying cardiac disease, exertional and resistive behaviour) and all of these are independent of the application of an [electronic control device].[239]

Dr. Ho concluded, "[I]t is my opinion, to a reasonable degree of medical certainty or probability, that the use of the TASER ECD did not cause or contribute to [Mr. Dziekanski's] death."[240]

In his testimony, Dr. Ho said that the phenomenon of sudden death during restraint typically involves agitated males with an average age of about 40, who are acting bizarrely (e.g., running out in traffic naked, attacking bystanders or the side of a house); showing elevated vital signs, elevated temperature, apparent hallucinatory or psychotic activity where the person appears to be responding to external stimuli (e.g., hearing voices); resistant to help; attracted to things that reflect or are bright and shiny; and who may have altered perception of pain, an underlying health problem, and ingestion of medications or illicit toxins or drugs. The first recorded cardiac rhythm is frequently pulseless electrical activity or asystole.

He said that the evidence of Mr. Dziekanski being agitated and showing signs of exertion is consistent with his own recent research that found 45 seconds of vigorous exertion is enough to make a person really ill from a metabolic acidosis standpoint. He disagreed with Dr. Tseng's opinion that Mr. Dziekanski experienced sustained ventricular tachycardia for seven or eight minutes, and then devolved into ventricular fibrillation, and then asystole. He was not aware of any human research showing this, and it has not arisen in his clinical practice nor in any of the 600-700 subjects he has tested.

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[239] Exhibit 141A, p. 20. Dr. Ho's repeated characterizations of Mr. Dziekanski's "volitionally elevated state of metabolic demand," "elective physical resistance," "resistive behaviour," and "voluntary fighting" imply that Mr. Dziekanski was consciously and deliberately resisting the police officers. The evidence does not support that implication. In my view, such imputations of blameworthiness have no place in what should be a neutral medical opinion.

[240] Exhibit 141A, p. 20.

He was referred to several of his recent studies, which he said produced the following results:

- 15-second TASER applications with pre-placed thoracic electrodes over the cardiac axis of 44 subjects did not demonstrate any evidence of a dangerous arrhythmia.[241]
- Prolonged 15-second conducted energy weapon application in 25 exhausted human male volunteers did not cause a detectable change in their 12-lead electrocardiograms.[242]
- In a resting adult population of 66 human volunteers, the TASER X26 did not affect the recordable cardiac electrical activity within a 24-hour period following a standard five-second application. Additionally, no evidence of dangerous hyperkalemia or induced acidosis was found.[243]
- Preliminary data from a study to compare the human stress response to conducted electrical weapons, pepper spray, cold-water tank immersion, and a defensive tactics drill suggest that physical exertion during custodial arrest may be most activating of the human stress response, particularly the sympathetic-adrenal-medulla axis. Conducted electrical weapons were not more activating of the human stress response than other uses of force.[244]
- 15-second conducted energy weapon applications to 38 exhausted human volunteers were not associated with a worsening change in pH or troponin. Decreases in pCO_2 and potassium and a small increase in lactate were found.[245]
- 15-second conducted energy weapon applications to 52 human volunteers did not impair respiratory parameters.[246]

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[241] Exhibit 141D.

[242] Exhibit 141E.

[243] Exhibit 141F.

[244] Exhibit 141G.

[245] Exhibit 141I.

[246] Exhibit 141J.

Dr. Ho said that Mr. Enchelmaier's observations of Mr. Dziekanski's pulse and breathing were

> ... very consistent with many of the resuscitations that I've been involved in, where the person is extremely acidotic after some type of a huge exertional event and they subsequently go on to die. And what ends up happening is their pulse, which starts out very fast to compensate for their acidosis, eventually, because they become so acidotic their body can no longer operate correctly under that and they can't compensate for it any more, their heart begins to slow down, and we call that – they have a Brady arrhythmia, to the point where eventually their heart function stops and they are either found in a presenting rhythm of asystole or something called pulseless electrical activity, which is basically you may see electrical spikes on the cardiac monitor, but their heart is refusing to make any squeezing action. So I think it's very consistent with that. It's consistent with my research. It's also consistent with other literature in the area of known metabolic acidosis.[247]

He generally agreed with Dr. Di Maio's, Dr. Pollanen's, and Dr. Swerdlow's opinions about Mr. Dziekanski's cause of death. With respect to Dr. Butt's opinion that increasing exertion and stress seen following the discharge of the weapon likely contributed to death, Dr. Ho said this was an oversimplification:

> So to be able to list that, you know, simply the TASER increases the amount of stress, I don't believe that that is the case. And again, if you look at the catecholamine paper that we talked about, the TASER is the least likely to give a physiologic rise in any of the stress parameters when you compare it to all of the other things that are going on, such as, you know, continued resistance, voluntary fighting, you know, those types of things.[248]

3. Dr. William Bozeman

Dr. Bozeman is an emergency physician in North Carolina and associate professor, director of prehospital research at Wake Forest University's Department of Emergency Medicine. He specializes in prehospital care and resuscitation, and is a researcher into TASER-related medical effects. Although he did not testify at our evidentiary hearings, he reviewed audiovisual and written materials respecting the Dziekanski case and provided a written opinion that stated in part:

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247 Transcript, May 11, 2009, p. 23.

248 Transcript, May 11, 2009, p. 37.

> Though it is impossible to conclusively determine without concurrent ECG monitoring, I feel that it is very unlikely that the TASER caused or significantly contributed to the unfortunate death of Mr. Dziekanski beyond the general stress of the physical subdual process.
>
> That said, I do note that Mr. Dziekanski's physical collapse and cessation of purposeful resistance did occur within a short period (roughly 90 seconds) after two discharges of a TASER in probe deployment mode with an anterior thoracic, likely transcardiac, discharge vector. Though not conclusively demonstrating a TASER-related effect, this clinical course is consistent with, among other things, the TASER's electrical discharge contributing to a cardiac dysrhythmia and thus to Mr. Dziekanski's demise. Acknowledging that our current knowledge is incomplete and that significant disagreement exists among experts regarding the potential for the TASER to affect the human cardiac cycle, I cannot completely discount the animal data and human case report that suggest that this may be a rare possibility. Therefore I cannot fully rule out that the TASER weapon may have contributed to Mr. Dziekanski's death.[249]

E. PSYCHIATRISTS

1. Dr. Shao-Hua Lu

Dr. Lu has a medical degree from Dalhousie University. He completed a residency in psychiatry at the University of Ottawa and a clinical fellowship in addiction psychiatry at Harvard University. He is currently a clinical assistant professor in the Department of Psychiatry at the University of British Columbia and is on staff in the Consultation-Liaison Psychiatric Service at Vancouver General Hospital, providing consultation, liaison, and psychiatry care to medical and surgically ill patients. For 10 years he has treated patients with delirium, alcohol withdrawal, and other types of medically related psychiatric conditions. I qualified him as an expert in psychiatry and addiction medicine.

In April 2008, after reviewing the Pritchard video and an extensive volume of documentary material, Dr. Lu provided the Integrated Homicide Investigation Team with a written medical-psychiatric opinion regarding Mr. Dziekanski's mental state prior to the incident with the RCMP. In a subsequent July 2008 report, written after his review of additional witness statements, he confirmed his opinion.

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[249] Exhibit 124, p. 1.

In his report, Dr. Lu stated that there is a high degree of certainty that Mr. Dziekanski was in a state of agitated delirium prior to the police incident and his death, and that there were no other potential medical-psychiatric conditions that could better account for his behaviours and mental status. He said that delirium is a complex neuropsychiatric disorder primarily characterized by generalized impairment of cognition and general brain functions. Disorientation, poor attention, and poor concentration are almost universal. Delirium has a wide range of non-cognitive symptoms, including changes in psychomotor behaviours with agitation, excitation, and defensive aggression. An individual's thinking, language, perception, and emotional tone are disturbed. Visual and auditory hallucinations are common, often unpleasant, frightening, or threatening. Delirium typically has an acute onset, and often worsens at night and is exacerbated by sleeplessness. He stated:

> Mr. Dziekanski demonstrated classic features of delirium especially based on the Pritchard video footage. He demonstrated psychomotor agitation, disorganized behaviours. He appeared both frightened and defensively threatening. His aggressive behaviours did not appear to aim at any individual in particular or to achieve a specific purpose. Mr. Dziekanski demonstrated a decreased awareness of his surroundings. Mr. Dziekanski's behaviours are not typical of [an] individual in an unfamiliar environment or individual coping with language barriers. He did not respond to bystanders' attempt to communicate with him. Although based on limited information, it is clear that Mr. Dziekanski had disturbances in cognition. His actions were not predictable. He appeared to have difficulty organizing and coordinating his actions and behaviours.[250]

Dr. Lu said that it was impossible to retrospectively give a precise cause for Mr. Dziekanski's delirium. However, he had numerous risk factors, including lack of restful sleep, anxiety, vomiting, fatigue, autonomic disturbances (e.g., thirsty, sweating, laborious breathing), electrolyte imbalance, and possible alcohol withdrawal.

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[250] Exhibit 77, pp. 13-14.

In his testimony, Dr. Lu stated that laborious breathing is often a sign either of dehydration or autonomic instability, the latter of which refers to physiological changes in the body where there is increased heart rate, increased respiratory rate, and increased or changed blood pressure. Some people in a delirious state can exhibit greater than normal strength. When a delirious person exhibits defensive aggressiveness, sometimes de-escalation techniques work, but sometimes they do not work. It would not be unusual for a delirious person exhibiting defensive aggressiveness to grab whatever is present as a defensive measure.

Dr. Lu said that he did not consider Mr. Dziekanski to be in a really mean, angry state. Rather, he was more frightened and scared, leading to behaviours of defensive aggression.

In May 2009 Dr. Lu provided a third report (Exhibit 155), responding to reports provided by Drs. Chambers, Kerr, Tseng, and Janke, in which he stated:

- ***Dr. Chambers*** – he agreed that Mr. Dziekanski did not have delirium tremens. However, he was hyperventilating (an involuntary activity), which is commonly observed in delirium. Dr. Chambers also identified an increased heart rate and blood pressure, which are almost always encountered in individuals with delirium.
- ***Dr. Kerr*** – the hyperadrenergic state described by Dr. Kerr is consistent with the medical opinion that Mr. Dziekanski was experiencing delirium.
- ***Dr. Tseng*** – he agreed that without exposure to the conducted energy weapon, it is unlikely that Mr. Dziekanski would have experienced sudden death.
- ***Dr. Janke*** – he disagreed with Dr. Janke's dismissal of the significance of Mr. Dziekanski hyperventilating, stating that it is almost always a sign of some kind of physiological distress. He added that Dr. Janke's understanding of dehydration was incomplete – individuals with potential alcohol withdrawal, dehydration, and delirium can have significant fluid imbalance that oral fluid and a few glasses of water will

not replace. He added:

> Mr. Dziekanski's delirium resulted in a physiological vulnerable state that increased his susceptibility to the cardiac impacts of TASER as outlined by Drs. Chambers, Kerr, and Tseng.[251]

2. Dr. Paul Janke

Dr. Janke received his medical degree from the University of British Columbia in 1982. He completed a year of internal medicine at St. Paul's Hospital in Vancouver, and then a residency in psychiatry at UBC (1987), including a rotation in forensic psychiatry at Youth Forensic Psychiatric Services. He is a Fellow of the Royal College of Physicians of Canada in Psychiatry. He currently maintains a private practice in forensic psychiatry and also has a sessional appointment as the regional clinical director of the South Burnaby Region of Youth Forensic Psychiatric Services. I qualified him as an expert in forensic psychiatry.

Dr. Janke reviewed the Pritchard video and numerous documents provided by Commission Counsel. In his written report, Dr. Janke noted that Mr. Dziekanski was responsive to direction from the RCMP officers. The translation of his statements recorded on the video indicates that he had awareness of his surroundings and he was making comments that were consistent with the circumstances he found himself in. There is no indication that he was disoriented or was experiencing delusional thinking or hallucinations. The pathologist (Dr. Lee) noted no medical condition that may cause delirium, which corresponds with the video showing Mr. Dziekanski to be agitated but not delirious.

Dr. Janke disagreed with several aspects of Dr. Lu's opinion:

- It was unclear how Dr. Lu could come to the conclusion that Mr. Dziekanski appeared to be in a state of moderate to severe psychomotor agitation. Throughout much of the video, Mr. Dziekanski appeared relatively calm, was interacting with others, and was attempting to engage in conversation with others.

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[251] Exhibit 155, p. 3.

- Mr. Dziekanski was quite aware that his actions caused the automatic door to open and close. On other occasions, he appeared to deliberately move things in order to prevent the door from automatically opening and closing.
- It was unclear how Dr. Lu concluded that Mr. Dziekanski was noted to move chairs around in an unclear fashion. To the contrary, his actions appeared to be deliberate and purposeful – he moved the chairs in front of the doorway to fashion a sort of barrier.
- It was unclear how Dr. Lu could come to the conclusion that Mr. Dziekanski did not respond to efforts by bystanders to calm him. There were several times when Mr. Dziekanski appeared to interact with bystanders, appearing to calm down somewhat and attempting to communicate with them. At one point he raised the computer monitor, and then put it down after several people shouted, "No."

Dr. Janke disagreed with Dr. Lu's opinion that Mr. Dziekanski was in a state of agitated delirium. The Pritchard video shows an individual who was at times agitated and angry, which would be consistent with an individual who had been in transit for 30 hours, had in all likelihood little in the way of restorative sleep, had likely consumed only water during the final 10 hours, and was experiencing a severe language barrier. He added:

> Furthermore, it would be my considered opinion that observing a short amateur video of an individual interacting in an environment cannot provide sufficient information to reach a medical opinion with respect to an individual's mental state. The diagnosis of delirium requires direct physical assessment of an individual including direct attempts at interviewing of the individual. Review of documentation showing an altered mental state over a period of time would also be an essential feature in making a diagnosis of delirium.... Dr. Lu uses the minimal information available through the Pritchard video to speculate on Mr. Dziekanski's internal thought processes.... It is my opinion that the Pritchard video provides insufficient information to reach the conclusion that Mr. Dziekanski was in a delirious state.[252]

Dr. Janke added that Dr. Lu's comments with respect to possible physical factors that could contribute to the development of delirium represented speculation. With respect to his comments respecting autonomic disturbance, Dr. Janke stated that it is well-recognized that anxiety can cause individuals to sweat and breathe heavily –

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[252] Exhibit 154, pp. 6-7.

certainly Mr. Dziekanski's circumstances could lead to the assumption that he was experiencing quite significant anxiety. In his view, attributing Mr. Dziekanski's delirium in part to electrolyte imbalance was purely speculation. He concluded:

> It would be my forensic psychiatric opinion that the information available to us with respect to Mr. Dziekanski's mental status does not allow a diagnosis of delirium to be made. Given the material available to us, in my opinion diagnosis should be restricted to observations that he was agitated, distressed, and anxious and no further conclusions can be drawn from a medical forensic psychiatric perspective.[253]

In his testimony, Dr. Janke acknowledged that in a clinical setting he might diagnose delirium about once a year while Dr. Lu, when working in consultation-liaison psychiatry, might do so on a daily basis. He said that patients in alcohol withdrawal have a tendency to go into delirium, which can be fatal. They are treated with intravenous fluids and vitamins, and with medications to treat their agitation and delirium.

Dr. Janke said that from his review of the Pritchard video and the translation of Mr. Dziekanski's statements recorded on it, it appears that he was happy to see the police initially, based on his tone of voice. However, he then becomes what appears to be puzzled or upset by their actions, which is when he made the comment, "Leave me alone. Did you become stupid? *Or*, Have you lost your minds?"

In response to Dr. Lu's statement (in his third report) about the significance of hyperventilation, Dr. Janke said he agreed that hyperventilating is almost always a sign of some kind of physiological distress, but that it is not relevant to a diagnosis of delirium. He disagreed with Dr. Lu's comments about dehydration, because they assumed delirium.

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[253] Exhibit 154, p. 7.

F. EPIDEMIOLOGIST

Dr. Keith Chambers

Dr. Chambers has a medical degree (1973) and a master's degree in clinical epidemiology (1990) from the University of British Columbia. He has clinical experience in internal medicine and emergency medicine, and practised as a family physician between 1975 and 1996. He practised as a consultant epidemiologist at BC Children's Hospital between 1990 and 1995, and then became assistant director of the Epidemiology Evaluation Unit at Vancouver General Hospital. Since 2003 he has been an associate clinical professor in the Health Care and Epidemiology Department of the UBC Faculty of Medicine, and he also maintains a consulting practice in clinical epidemiology. I qualified him as an expert in clinical epidemiology, emergency medicine, and family practice.

In his written report (Exhibit 148), Dr. Chambers reviewed the sequence of events at the Airport before and after the conducted energy weapon was deployed. He calculated that Mr. Dziekanski was handcuffed approximately 90 seconds after the start of the struggle, and 15-20 seconds later Cst. Bentley observed him turn blue, indicating a loss of circulation and cyanosis. Since cyanosis takes time to develop, one can infer that he was developing cyanosis for a period of time prior to this observation. The possibility exists that the fatal arrhythmia could have developed within a minute of the third deployment of the conducted energy weapon. He added:

> The logical sequence of first developing an arrhythmia, then going unconscious and later developing cyanosis makes intuitive sense. This is as opposed to the alternative order of going unconscious then developing an arrhythmia. It is difficult to understand, in the absence of a blow to the head or a seizure, why a prone person, with a good carotid pulse, would go unconscious.
>
> However, against this logical sequence of events is the testimony that Mr. Dziekanski's breathing and pulse were monitored during this period. If it is true that he did, in fact, have a pulse and was breathing up until close to the time when cyanosis [was] noted, then the arrhythmia must have developed minutes after the third TASERing and direct capture of the heart by the TASER can be ruled out. However, if the assessments that were done were

> inadequate to correctly monitor the pulse and breathing, then direct capture of the heart and the possibility of an arrhythmia such as ventricular tachycardia remains a possibility.[254]

Dr. Chambers reported that, based on the negative autopsy, one can assume that Mr. Dziekanski suffered an electrical death – his heart developed a fatal arrhythmia, although we will never know for sure the actual arrhythmia that led to his death. The next step in determining probable causation is to assess those risk factors that might have caused the fatal arrhythmia. In Mr. Dziekanski's case, heart attack, coronary ischemia due to atherosclerosis, and death due to drugs can be ruled out. We can also rule out delirium tremens (given the time frame and the absence of delusions, hallucinations, tremors, and other typical manifestations) and "excited delirium" (the syndrome's main common presenting features were not present; he was not immune to pain, nor was there evidence of cocaine use or psychosis). Turning to other potential risk factors, Dr. Chambers said that Mr. Dziekanski was undoubtedly stressed out and exhausted, both of which can cause physiological changes in the body:

> A term "hyperadrenergic state", as adrenaline is involved, is used here to describe this physiological response to acute stress. It is known that it can be associated with hyperventilation such as was seen on the video. It is my opinion, that Mr. Dziekanski's heart would have been somewhat stressed during this period leading up to the restraint period. He was probably hyperventilating, his blood pressure was probably elevated and his heart rate would have been raised from normal. This would have increased the stress on his heart and in particular on the electrical part or conduction system of the heart.[255]

However, Dr. Chambers added that it is significant that any susceptibility to an arrhythmia (e.g., mild cardiomyopathy, if it existed at all) had to have been there for years, without causing a fatal arrhythmia. Even the added stress and fatigue since leaving Poland did not trigger one. However, within a minute or two from the start of the restraint effort and the use of the TASER, Mr. Dziekanski had died. This relatively short period of time, as well as the strong temporal relationship to his death, forces us

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254 Exhibit 148, pp. 7-8.
255 Exhibit 148, p. 13.

to consider these two remaining risk factors and possible mechanisms by which one or the other, or both, could be causally related to his death.

The mechanisms by which the stress of physical restraint can trigger sudden death involve activation of our primitive "fight or flight" response. Adrenaline, cortisol, noradrenaline, and many other neurohormones are released, causing increases in blood pressure, the heart rate, the metabolic rate, and blood sugar. Glycolysis occurs in the liver and muscle stores of energy. Byproducts can include lactic acid and a more acid environment in the blood. The heart becomes more vulnerable to fatal cardiac arrhythmias.

This mechanism would also apply to the response to stress caused by deployment of a conducted energy weapon, driven by the extreme pain and muscle feedback to the brain via spinal cord pathways due to the effects of repeated discharges. This, plus the associated anxiety of being hit with a TASER and the effects of immobility would certainly have caused a severe "fight or flight" response. It is also possible that metabolic acidosis, triggered by the release of lactic acid from the sudden capture and tetany of nearly all the large skeletal muscles in the body, rendered the heart more susceptible to a fatal arrhythmia.

Dr. Chambers said that the Pritchard video assists in assessing the relative impact of physical restraint and the conducted energy weapon in contributing to the electrical death of Mr. Dziekanski. It appears that the weapon had a far more violent effect. He cried out in pain several times, dropped to the ground, and writhed. His outward response to physical restraint appears to be significantly less violent and reactive. He concluded:

> In my opinion, the two most significant contributing causes of the death of Mr. Dziekanski were the act of TASERing and the act of physical restraint. Further, the mechanism of death was most likely the creation of a hyperadrenergic state that caused or brought on a fatal arrhythmia, although the possibility of direct capture of the heart and the development of ventricular tachycardia cannot entirely be ruled out.

> The extended period of TASERing appears on the tape by Pritchard to have been a great deal more stressful to Mr. Dziekanski than the act of physical restraint. So while both most likely contributed to the death of Mr. Dziekanski, in my opinion, the act of TASERing Mr. Dziekanski for 31 seconds over a period of 49 seconds, contributed more to his stress response and subsequent demise than physical restraint.[256]

In his testimony, Dr. Chambers said that it was highly unlikely that there could have been any pulse or breathing after the cyanotic evidence was noted:

> The cyanosis is a lack of oxygenation; it takes time to develop. So you'd have to have significant pump failure for a period of time prior to cyanosis developing. And therefore that would argue that the arrhythmia had started sometime prior to the cyanosis developing.[257]

When asked about Mr. Enchelmaier's testimony about taking three pulses, Dr. Chambers said that the video shows that Mr. Enchelmaier spent only about seven seconds taking the pulse. He said that in non-stressful situations, you would want to take the pulse for at least 30-60 seconds. In stressful environments like this, he said that he was not sure how even a trained physician could in seven seconds be assured that it was the patient's (and not the physician's) pulse that was being recorded, that it was a regular pulse and get some idea of the rate.

Dr. Chambers said that volunteer studies involving 40-50 subjects, often done under ideal circumstances, are not designed to test real-world situations, and it is very difficult to draw conclusions from them.

Dr. Chambers said that based on his review of the medical literature respecting sudden death following restraint, if you eliminate cases involving illicit drug use, heart disease, severe psychiatric mental illness, and wildly agitated purposeless movement, "you're getting into a pretty rarefied air there."[258]

Dr. Chambers was asked to comment on excerpts from several medical reference books, and he indicated that he agreed with some excerpts and disagreed with others.

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[256] Exhibit 148, p. 20.

[257] Transcript, May 13, 2009, p. 80.

[258] Transcript, May 13, 2009, p. 128.

He was asked whether he agreed with the statement by one author that when some sudden deaths during restraint "cannot be adequately explained by injuries produced by lethal pathophysiology of the procedures themselves, it is clear that the deaths are coincident with but not caused by the restraint procedure."[259] He responded:

> I couldn't disagree more. I think that's the whole problem here is, you know, if the way out of this problem is to – is to stick our heads in the sand and say, you know, it's coincident, then I think we're doing society a disservice. I think it is incumbent upon us to give our best opinion as to the pathophysiological mechanism and get on with it, and I think that's being done in a lot of areas of literature, and I think even in this chapter later on when she describes the response. But to say it's coincident, I – it just, it's wrong. Mr. Dziekanski died for a reason. It wasn't coincidence.[260]

Dr. Chambers was also asked to comment on several studies reported in medical journals on conducted energy weapons. He agreed with some findings and disagreed with others, and stated that it would be unsafe to extrapolate findings from studies using a small number of volunteer subjects. When looking at rare events, such as the death of Mr. Dziekanski, one needs large sample sizes in order to figure out what is going on. "If your sample size is below your event rate, you're not going to see it."[261] He added that a Ph.D. statistician with whom he works has calculated that a sample size of between 20,000 and 30,000 would be sufficient to produce reliable results.

Dr. Chambers disagreed with Dr. Di Maio's opinion of chronic alcohol abuse and alcohol withdrawal. Severe alcoholics typically have a long history, which is absent in this case. In addition, it is remarkable that Dr. Di Maio excluded the conducted energy weapon as a risk factor.

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[259] Transcript, May 14, 2009, p. 23.

[260] Transcript, May 14, 2009, pp. 23-24.

[261] Transcript, May 14, 2009, p. 64.

G. ELECTRICAL ENGINEER

Dr. Dorin Panescu[262]

Dr. Panescu received a Bachelor of Science degree (1985) in Romania, and Master of Science (1991) and doctorate degrees (1993) in electrical and computer engineering from the University of Wisconsin-Madison. He served as principal staff scientist, Cardiac Rhythm Management, at St. Jude Medical in Sunnyvale, California, and is currently chief technical officer at NewCardio, Inc., in Santa Clara, California. He is a senior member of the Institute of Electrical and Electronics Engineers and a Fellow of the American Institute of Medical and Biological Engineering. I accepted him as an expert in conducted energy weapons and their electrical effect on the heart from an electrical and bioelectrical perspective.

In his written report (Exhibit 108), Dr. Panescu offered opinions on 14 matters, including the following:

- The voltage, current, and charge delivered by a TASER X26 device are, by a very wide margin, significantly below thresholds known to be capable of inducing ventricular fibrillation. Electricity, including currents from a TASER X26, cannot directly trigger asystole or pulseless electrical activity.
- If any fraction of the TASER X26's voltage, current, or charge reached Mr. Dziekanski's heart, the residual level was significantly below, by a very wide margin, scientifically accepted thresholds required for induction of ventricular fibrillation. Similarly, they would have been insufficient to capture or pace Mr. Dziekanski's heart.
- With a high degree of scientific and electrical engineering probability, the first deployment of the weapon did not induce ventricular fibrillation in Mr. Dziekanski, nor did it capture his heart.
- Based on the video evidence of Mr. Dziekanski rolling on the floor and the testimony of Cst. Millington that he heard a loud noise from the weapon during the third deployment, it is highly likely, with a high probability of scientific and engineering confidence, that the second

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[262] Dr. Panescu acknowledged that he is an independent medical consultant to TASER International, Inc. In 2008 he invoiced TASER more than $92,000 for expert consulting work, including preparing reports and depositions, and speaking engagements.

and third weapon deployments did not induce ventricular fibrillation in, nor could they capture, Mr. Dziekanski's heart.

- The weapon's pulses delivered on Mr. Dziekanski's shoulder area in push-stun mode could not have had the strength to induce ventricular fibrillation or to capture his heart.
- Given Mr. Dziekanski's body mass index, and an estimated minimum skin-heart distance of about 31.1 mm, it is highly likely that his body geometry further protected his heart by attenuating the electrical current delivered by all five weapon discharges.
- A significant body of peer-reviewed literature has proved that the concept of delayed ventricular fibrillation does not have scientific merit; Mr. Dziekanski did not experience this.
- With a high degree of scientific certitude, Mr. Dziekanski's death was not caused or contributed to by the use of the conducted energy weapon.

After reviewing the reports and transcripts of Drs. Tseng, Chambers, and Kerr, Dr. Panescu provided a second written report (Exhibit 174). His disagreements with their findings and conclusions included the following:

- ***Dr. Tseng*** – the autopsy report did not substantiate full penetration of the dart electrodes through Mr. Dziekanski's skin. It was not established that the vector of the probes was along the cardiac axis. Dr. Tseng's entire report is flawed because it was based on the wrong skin-heart distance requirements for direct electrical induction of ventricular arrhythmias. Although Dr. Tseng credited the conducted energy weapon for the adverse physiological effects that triggered a sustained ventricular tachycardia, he failed to mention that if other restraining measures had been employed (e.g., baton or pepper spray), the end result would have been the same or worse. He also ignored the fact that the second through fifth weapon discharges were in open circuit, and were not continuous. While Dr. Tseng cited his own study, he failed to mention other studies that confirm a significant decrease in in-custody sudden deaths after introduction of TASER conducted energy weapons. Finally, he speculated without any evidence that without exposure to conducted energy weapon discharges, Mr. Dziekanski would not have died.
- ***Dr. Chambers*** – after citing the conducted energy weapon for contributing to the death because of the extreme pain and resulting stress, Dr. Chambers should have discussed the comparative potential effects that batons, pepper spray, or other restraining devices would

have had. The actual effective current delivery of the weapon was much shorter than Dr. Chambers' stated 49 seconds,[263] and the third to fifth discharges could not have produced the stress that Dr. Chambers was presuming in constructing his opinion.

- ***Dr. Kerr*** – he made an unqualified implication that TASER conducted energy weapons may cause ventricular arrhythmias during the vulnerable period of the cardiac electrical cycle, when such an assertion was not applicable, given the specific facts of this case. He failed to compare the alleged TASER X26 exacerbated hyperadrenergic state to the potential effects of other restraining means, such as hog-tying, batons, and pepper spray. Finally, he speculated on the possible direct induction of ventricular arrhythmias by the TASER X26.

H. FINDINGS OF FACT AND CONCLUSIONS

1. Introduction

Before making any findings of fact or reaching any conclusions respecting cause of death, I gave careful consideration to the written and oral closing submissions of counsel for the participants.

There appeared to be general consensus among the medical experts that Mr. Dziekanski suffered an electrical death, which I understand to mean that he experienced a fatal cardiac arrhythmia that caused cardiac arrest. The process by which that fatal arrhythmia developed, and when it developed, was the subject of considerable debate and disagreement among the experts.

2. Determining the time of Mr. Dziekanski's death

We know that at approximately 1:45 a.m., when the basic life support paramedics attached the automated external defibrillator to Mr. Dziekanski, they obtained a "no shock advised" reading, which told them that his heart was not shockable. We also know that about two minutes earlier (1:43 a.m.), the Richmond firefighters determined that Mr. Dziekanski was not breathing and did not have a pulse. I

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263 Dr. Panescu's reference was incorrect. Dr. Chambers did not testify that the effective current delivery was 49 seconds, but only that the weapon was deployed for a total of 31 seconds over a period of 49 seconds.

interpret that to mean that at that time his heart was stopped, and necessarily must have stopped at some earlier time.

It is important to determine, as best we can, when Mr. Dziekanski died, because that will assist in drawing conclusions respecting the most likely cause of his death. During the evidentiary hearings, a great deal of evidence was led about the chronology of events at the Airport after the arrival of the four RCMP officers. This included radio communications among Airport personnel; E-Comm, BC Ambulance Service, and RCMP radio dispatches; Airport closed-circuit videos; and the Pritchard video. All these sources of information recorded the time of specific events or, in the case of the videos, recorded either the clock time or the number of minutes and seconds from when the video equipment began recording images.

I am indebted to counsel for the Vancouver Airport Authority for combining these various sources of information into one chronology and synchronizing the different timing systems. The most significant events in this chronology are set out below (shown as minutes and seconds after 1:00 a.m., on October 4, 2007).

TABLE 1: Chronology of events (shown as minutes and seconds after 1:00 a.m.)

Minutes	Seconds	Event
28	33	First contact between RCMP and Mr. Dziekanski. Cst. Bentley says: "How are you, sir? What's going on, bud?"
28	59	Beginning of first conducted energy weapon discharge, which lasted for six seconds (probe mode)
29	07	Beginning of second conducted energy weapon discharge, which lasted for five seconds (probe mode)
29	14	First RCMP officer attempts to restrain Mr. Dziekanski
29	23	Cpl. Robinson says to Cst. Millington: "Hit him again, hit him again."
29	24	Beginning of third conducted energy weapon discharge, which lasted for five seconds (probe mode)
29	34	Beginning of fourth conducted energy weapon discharge, which lasted for nine seconds (push-stun mode)
29	44	Beginning of fifth conducted energy weapon discharge, which lasted for six seconds (push-stun mode)
30	15	The handcuffs have been placed on Mr. Dziekanski

Minutes	Seconds	Event
30	39	Mr. Dziekanski appears to cease struggling or moving
31	05	Cst. Bentley radios for an ambulance – routine response
31	29	Cst. Bentley radios again, requesting that the ambulance be upgraded to Code 3, after seeing that Mr. Dziekanski's face had turned blue
32	53	Mr. Enchelmaier kneels down, takes Mr. Dziekanski's carotid pulse for seven seconds, then stands up and moves away
42	09	Richmond Fire-Rescue arrives in the International Reception Lounge
43	57	Basic life support paramedics arrive curbside

Two contradictory scenarios emerge from the evidence. The "continued breathing" scenario postulates that Mr. Dziekanski was last observed breathing about two minutes before the Richmond firefighters arrived (they arrived at 42:09), which means that he continued to breathe for at least 10 minutes after the time that the handcuffs were applied (30:15).

The "cyanosis" scenario postulates that the evidence of Mr. Dziekanski's face being blue at 31:29 means that this cyanotic condition (i.e., inadequate oxygenation of the blood) must have been developing for some time (either directly or as a result of respiratory failure), most likely because of cardiac failure. This would mean that Mr. Dziekanski's heart stopped pumping during the preceding 50 seconds, after he ceased struggling (30:39) and before his face turned blue (31:29).

From my review of the evidence, I have concluded that the "cyanosis scenario" outlined above is the more likely sequence of events and that, consequently, Mr. Dziekanski most likely died some time between when he ceased moving (at 30:39) and when his face was observed to be blue (at 31:29). That means that he died at most 75 seconds after he was handcuffed, and at most two minutes after the completion of the third probe-mode deployment of the conducted energy weapon. I have reached this conclusion for the following reasons.

First, there is indisputable evidence that Mr. Dziekanski's face had turned blue by 31:29. Cst. Bentley testified that he saw this, recognized that they now were dealing with a medical emergency and, for that reason, called RCMP dispatch with a request that the ambulance he had asked for 24 seconds earlier be upgraded to Code 3. Although Cst. Bentley did not remember saying anything to any of the other officers about this, Cst. Millington confirmed in his testimony that Cst. Bentley told him that he had upgraded the ambulance to Code 3 because he had seen Mr. Dziekanski turn blue. Cpl. Robinson also testified that he was aware that Mr. Dziekanski had turned blue, although he said it was his ear, not his face. Three civilian witnesses also testified that they saw Mr. Dziekanski turn blue:

- Alison Kula saw his hands go very dark purple and then very blue 30 seconds after he was handcuffed,
- Genevieve Deziel saw his face and hands turn blue within a minute of being handcuffed, and
- Lance Rudek saw his hands look a little reddish or bluish, after he was handcuffed.

Second, turning blue (i.e., cyanosis) is a sign of inadequate circulation of oxygenated blood and is recognized as a medical emergency. Dr. Lee, the pathologist who performed the autopsy, testified that turning blue is an indication that the person is in cardiac arrest or close to it. Dr. Chambers testified that there must have been significant pump failure before the cyanosis was visible.

Third, I accept Dr. Chambers' testimony that the logical sequence of events would be for a person to first develop an arrhythmia, then go unconscious, and then become cyanotic. He added, "This is as opposed to the alternative order of going unconscious then developing an arrhythmia. It is difficult to understand, in the absence of a blow to the head or a seizure, why a prone person, with a good carotid pulse, would go unconscious."[264] Dr. Lee testified to the same effect, that it would be speculative to say that Mr. Dziekanski stopped breathing before his heart stopped.

Fourth, the "cyanosis" scenario means that Mr. Dziekanski died at most 75 seconds after an intense period of weapon discharges and physical struggling with three police officers, whereas the "continued breathing" scenario means that Mr. Dziekanski lay undisturbed (unconscious and breathing well) for at least 10 minutes after the handcuffs were applied and then, for no apparent reason, went into cardiac arrest during the ensuing 2-3 minutes. Something must have triggered the cardiac arrest. For the reasons I will discuss in more detail when exploring the most likely cause of death, I am satisfied that cardiac arrest proximate in time to intensely stressful activities is more plausible than cardiac arrest after 10 minutes of undisturbed rest.

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[264] Exhibit 148, pp. 7-8.

Fifth, the "continued breathing" scenario is principally dependent on the testimony of Trevor Enchelmaier, the Securiguard shift manager, whose evidence I summarized in Part 5. He testified that he took Mr. Dziekanski's carotid pulse three times, that he spent 10-30 seconds taking each pulse, and that the pulses were, in order, very strong and fast, strong but slower, and clear and slow. The Pritchard video shows Mr. Enchelmaier taking Mr. Dziekanski's carotid pulse once, for seven seconds. Several other witnesses testified that they saw a man in a suit (who I infer to be Mr. Enchelmaier) take Mr. Dziekanski's pulse once. Several aspects of Mr. Enchelmaier's testimony cause me to question the accuracy of his recollection – his overestimation of the time he spent taking Mr. Dziekanski's pulse each time, and the fact that he was not aware that Mr. Dziekanski was cyanotic until after the paramedics arrived. Also, I accept the testimony of several medical experts that it is doubtful that taking a pulse for seven seconds would enable a person with Mr. Enchelmaier's qualifications to provide the precise descriptions of each pulse that he did.

Sixth, the other evidence of Mr. Dziekanski's continued breathing is unpersuasive:

- Cst. Rundel testified that Mr. Dziekanski was breathing heavily soon after the handcuffs were applied, but he then left the scene to get hobbles from his car. After he returned, and about two minutes before the Richmond firefighters arrived, he knelt down near Mr. Dziekanski and heard him breathing and snoring.
- Cst. Bentley testified that Mr. Dziekanski's breathing was laboured around the time he went unconscious and turned blue, and realized that he might need cardiopulmonary resuscitation. He left the scene soon thereafter to retrieve a camera from his vehicle and did not monitor Mr. Dziekanski after that time.

- Cst. Millington testified that he did not check Mr. Dziekanski's pulse or breathing or check for airway obstruction, and he did not observe Cst. Rundel or Cst. Bentley do so. He asked Cpl. Robinson if Mr. Dziekanski was breathing, and Cpl. Robinson said, "Yes." Prior to the arrival of the Richmond firefighters, he did not observe anyone else check Mr. Dziekanski for pulse, breathing, or airway obstruction.
- Cpl. Robinson testified that he constantly monitored Mr. Dziekanski's breathing until the Richmond firefighters arrived. He did this by placing his hand on Mr. Dziekanski's chest, observing his mouth for breathing and placing his head close to Mr. Dziekanski's head so he could hear his breathing. Initially he heard what he thought was snoring, which alerted him to the fact that Mr. Dziekanski was unconscious. He said that he also checked Mr. Dziekanski's carotid pulse a couple of times, after Mr. Enchelmaier did so. The second Pritchard video shows Cpl. Robinson kneeling behind and leaning over Mr. Dziekanski's upper body soon after the handcuffs were applied, until the end of that video. The third Pritchard video shows Cpl. Robinson in a similar position, bending over Mr. Dziekanski in a manner consistent with checking for breathing, until Mr. Enchelmaier moves in and takes Mr. Dziekanski's pulse (at 32:53). After Mr. Enchelmaier moves away, Cpl. Robinson leans over Mr. Dziekanski again, in a similar fashion as before. There is no video record of the ensuing nine minutes, when the Richmond firefighters arrived. All three firefighters testified that when they entered the International Reception Lounge, no one was monitoring Mr. Dziekanski.

It appears that Cpl. Robinson did check Mr. Dziekanski's breathing initially, immediately prior to and shortly after Mr. Enchelmaier's intervention. I accept the evidence of the three firefighters that when they arrived no one was monitoring Mr. Dziekanski. Although Cpl. Robinson testified that he constantly monitored Mr. Dziekanski's breathing until the firefighters arrived, the evidence of the firefighters contradicts that, and in any event, Cpl. Robinson did not offer any detailed description of Mr. Dziekanski's breathing pattern or whether it changed over time. Cpl. Robinson's testimony implies that Mr. Dziekanski was breathing when the firefighters arrived, yet their initial assessment a minute later showed that he was not breathing.

Having regard to all the circumstances, I can place little reliance on the testimony of Cpl. Robinson that he constantly monitored Mr. Dziekanski's breathing until the firefighters arrived. Similarly, I find unpersuasive the testimony of Cst. Rundel that about two minutes before the Richmond firefighters arrived, he knelt down near Mr. Dziekanski and heard him breathing and snoring.

For all these reasons, I am satisfied that Mr. Dziekanski went into cardiac arrest first, then went unconscious, and finally showed signs of cyanosis, all within 75 seconds of being handcuffed.

3. Determining the cause of Mr. Dziekanski's death

The autopsy did not disclose an anatomical or toxicological cause of death. That rules out, for example, a chronic potentially immediately fatal medical condition, a blunt trauma, or an internal injury. Dr. Lee, the pathologist who performed the autopsy, described Mr. Dziekanski as reasonably healthy.

Given the autopsy findings, we will never know with absolute certainty what caused Mr. Dziekanski's death. In these circumstances, the best we can do is draw inferences from the known facts and reach conclusions about the most likely cause of death.

As noted earlier, there appeared to be general consensus among the medical experts that Mr. Dziekanski suffered an electrical death, which I understand to mean that he experienced a fatal cardiac arrhythmia that caused cardiac arrest. What I will now explore is the most likely mechanism that led to that tragic result. During our evidentiary hearings, the medical experts offered several different alternatives.

a. Pre-existing heart disease plus accumulated stress

Earlier in this report, I documented that, notwithstanding Mr. Dziekanski's excitement about immigrating to Canada, he was afraid of flying. He had rescheduled his flight once, and might have cancelled the trip entirely except for his mother's phone conversation with him shortly before his departure. His holding onto a heat radiator in the apartment, and his shaking and dizziness, suggest that at times he was in a panicky state. However, once he left for the airport he settled down, and his behaviour on both flights appears to have been uneventful.

By the time Mr. Dziekanski reached Vancouver, he was fatigued, confused, stressed, sweaty, and disheveled. Not finding his mother waiting for him at the baggage carousels, having no experience with international travel, and speaking neither of Canada's official languages undoubtedly compounded his stress and confusion. His disappearance from the Customs Hall video cameras for more than five hours remains unexplained, yet his subsequent dealings with Canada Border Security Agency officers were adequate for him to be processed for entry as an immigrant. Mr. Pritchard's video of Mr. Dziekanski in the International Reception Lounge shows a confused and distraught man, breaking a folding table and a computer and arranging his luggage in an apparent desire to form a barricade.

It was suggested that Mr. Dziekanski's accumulated stress and agitation could have triggered (before the arrival of the RCMP officers) a hyperadrenergic effect, whereby his system was flooded with adrenaline and catecholamines, and that this reaction, coupled with his pre-existing medical condition, could have overwhelmed his heart, leading to cardiac arrest. While I am satisfied that the hyperadrenergic effect (which I will discuss in more detail later) is crucial to an understanding of his death, I am not persuaded that the scenario I have described above adequately explains his death, for several reasons.

First, I am not convinced that Mr. Dziekanski had alcohol cardiomyopathy. While Dr. Lee observed dilated ventricles during the autopsy, which given his other observations (of cerebellar atrophy and fatty liver) were indicative of chronic alcoholism, his microscopic examination of sections of the heart did not confirm cardiomyopathy. He testified that this was, at most, a "finding," and it did not in his opinion cause or contribute to his death. Neither Dr. Pollanen nor Dr. Butt were prepared to say that Mr. Dziekanski had cardiomyopathy, and Dr. Kerr testified that he had, at most, very mild cardiomyopathy.

Second, I am not persuaded that Mr. Dziekanski was experiencing alcohol withdrawal after his arrival in Vancouver. While Dr. Sloane said that the evidence he reviewed was consistent with such a finding, Drs. Lee, Pollanen, Chambers, and Butt disagreed.

Third, while none of the medical experts suggested that Mr. Dziekanski was experiencing delirium tremens, one psychiatrist (Dr. Lu) expressed the opinion that he was in a state of agitated delirium, while another psychiatrist (Dr. Janke) disagreed, based on the evidence available. On this issue, having regard to the Pritchard video and the other evidence I heard, I find Dr. Janke's analysis and opinion more persuasive.

Fourth, and most importantly, these accumulated stresses and any pre-existing medical conditions did not cause, on their own, a fatal arrhythmia. When the four RCMP officers arrived, Mr. Dziekanski was unquestionably upset, but he recognized them as police officers, engaged with them, and cooperated with their request for identification.

b. *Weapon-induced direct capture of Mr. Dziekanski's heart*

It is not in dispute that an externally originating electrical current can capture a person's heart, which can sometimes result in ventricular fibrillation, in which the ventricles beat chaotically at about 300 beats per minute. Blood is not pumped throughout the body, the person inevitably collapses into unconsciousness within 5-15 seconds, and if the heart is not defibrillated within a few minutes, the person will die.

In recent years an intense debate has developed respecting whether the electrical current from a conducted energy weapon can trigger ventricular fibrillation. At our evidentiary hearings, several medical experts testified that no human volunteer studies have documented this phenomenon. To the contrary, other medical experts cited anecdotal cases and extrapolated from animal studies where anesthetized swine went into ventricular fibrillation under certain conditions. It is fair to say that if capture of the heart and ventricular fibrillation can result from a conducted energy weapon's electrical current, three preconditions are likely necessary – deployment in probe-mode, placement of the two probes across the cardiac axis, and a relatively small skin-to-heart distance.

A recent study by Dr. Swerdlow (who testified at our evidentiary hearings) included a significant finding that supports the proposition that the electrical current from a conducted energy weapon is capable of capturing the heart and triggering ventricular fibrillation. He determined that one out of 56 subjects collapsed immediately after a conducted energy weapon was deployed across his chest, and the first cardiac rhythm presented was ventricular fibrillation. The subject had no drugs or cardiac pathology. In relation to this subject, Dr. Swerdlow stated:

> The time sequence and electrode location are both consistent with electrically induced VF [ventricular fibrillation] in one subject (subject 1), and neither drug use nor cardiac disease provides alternative explanations. To the best of our knowledge, this is the first reported fatality suggestive of CEW-induced VF.[265]

For the purposes of my analysis, I will assume that the electrical current from a conducted energy weapon is capable of triggering ventricular fibrillation. The question I must address in this case is whether it in fact did so, leading to Mr. Dziekanski's death. From my consideration of all the relevant evidence, I have concluded that it is unlikely to have happened in this case, for the following reasons.

First, the only relevant deployments of the conducted energy weapon were the probe-mode deployments, and the time between the completion of the third and final probe-mode deployment (29:29) and Mr. Dziekanski's collapse into unconsciousness (at about 30:39 or thereafter) is too long a time period. The medical experts consistently told me that collapse into unconsciousness occurs within 5-15 seconds.

Second, it is not clear whether the placement of the two probes was across the cardiac axis. Although Dr. Lee concluded that a punctate abrasion on the midline of the chest, just below the sternum, was likely from one probe, there was no similar punctate abrasion from which one could determine whether they were on a cardiac axis. A mark on the side of the abdomen above the hip bone might have been caused by the probe, but even if it was, the evidence overall suggests that the second probe embedded in Mr. Dziekanski's shirt rather than his skin, which means that the axis between the two probes would vary each time the untucked shirt flapped against his skin.

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[265] Swerdlow, Charles, *et al.*, "Presenting Rhythm in Sudden Deaths Temporally Proximate to Discharge of TASER Conducted Electrical Weapons," (2009) 16 *Academic Emergency Medicine*, 1 at p. 8.

Third, even if the placement of the probes was across the cardiac axis, it is not known how deeply the one below the sternum embedded into his chest (if at all) or what the distance was between the tip of this probe and Mr. Dziekanski's heart. Thus, we are not able to calculate whether that distance was small enough for the electrical current to capture the heart.

On a related issue, several medical experts suggested that the weapon's electrical current might have triggered ventricular tachycardia that transitioned into ventricular fibrillation and then asystole. For example, Dr. Kerr said that it is possible that the weapon discharge could have directly induced ventricular arrhythmias, given that one of the probes appeared to be on the anterior chest, quite close to the heart. The discharges could have induced ventricular tachycardia that subsequently contributed to loss of adequate circulation, then transitioned to ventricular fibrillation and then asystole. Dr. Tseng said that even if there was no direct capture of the heart, the adverse physiological effects from the weapon discharges could have triggered a sustained ventricular tachycardia, which, because of Mr. Dziekanski's alcoholic cardiomyopathy, could have resulted in hemodynamic instability and collapse, followed by degeneration into ventricular fibrillation and asystole.

While this is an interesting hypothetical possibility, I think it unlikely to have been the mechanism of death in this case, having regard to the uncertain evidence respecting whether the two weapon probes vectored the heart and respecting whether Mr. Dziekanski had cardiomyopathy.

c. *"Sudden death during restraint" and/or "excited delirium"*

Several medical experts testified about a phenomenon whereby a person exhibiting bizarre behaviour will sometimes die soon after being restrained, for no apparent reason. Typically, such a person will act irrationally, will be unaware of their surroundings, will not be capable of complying with demands, will be hyperthermic, will often disrobe in public, will be impervious to pain, and will exhibit superhuman strength. Almost always, they will be intoxicated with an illicit stimulant such as cocaine and will have a history of serious mental illness. The medical experts indicated that the mechanisms of such deaths are not well understood, and that the terms "sudden death during restraint" and "excited delirium" have been coined as a way of clustering such similar deaths for future research purposes.

In my view, neither term is of much assistance in attempting to ascertain how Mr. Dziekanski died. They are at best descriptive of the cluster of physical symptoms and actions that often surround such deaths, but do not provide any insight into the mechanism of such deaths. For example, ascribing a death to "sudden death during restraint" gives no greater insight into the underlying medical cause of death than would "sudden death during a car accident." The same can be said for "excited delirium." It may be a convenient label to cluster frequently recurring physical conditions and activities, but offers no guidance as to the underlying physiological mechanisms that caused the death.

In addition, I do not think that either of these postulated conditions have any application to this case, since Mr. Dziekanski was aware of his surroundings, complied with directions, was neither impervious to pain nor intoxicated with an illicit drug such as cocaine, and had no history of serious mental illness.

d. The hyperadrenergic state arising from the weapon deployment and physical altercation

Since the stress and fatigue that accumulated before, during, and after Mr. Dziekanski's trip to Canada, and any pre-existing medical condition, did not collectively trigger his cardiac arrest, the logical question that must be asked is whether his subsequent interaction with the four RCMP officers did. By "interaction," I am referring to the multiple deployments of the conducted energy weapon and the physical wrestling that culminated in Mr. Dziekanski being handcuffed.

According to the chronology set out earlier, the first weapon deployment commenced at 28:59, he was handcuffed by approximately 30:15, and he stopped struggling by 30:39 (by which time, I have concluded, he went into cardiac arrest). To put it simply, the interaction with the officers took 75 seconds, and he likely went into cardiac arrest within the next 25 seconds.

Many of the medical experts discussed the hyperadrenergic effect, either in their written reports or their testimony, or both. After reviewing their evidence, I concluded that there was a refreshing degree of consensus that the hyperadrenergic effect plays a pivotal role in our understanding of how Mr. Dziekanski died. I will briefly summarize what they told me:

- ***Dr. Lee*** – said that in these types of cases, the adrenergic response is believed to be the mechanism of death – i.e., the adrenaline that flows through the body whenever the body is in a stressful or dangerous situation, and pain can increase the adrenergic response. This outflowing of adrenaline increases blood pressure and heart rate, which can potentially lead to an arrhythmia.
- ***Dr. Di Maio*** – said that the mechanism precipitating the fatal arrhythmia was most likely a hyperadrenergic state due to elevated levels of catecholamines produced by autonomic hyperactivity, psychomotor agitation, anxiety, and the struggle.
- ***Dr. Pollanen*** – said that if the excited delirium/prone-position restraint concept is accepted as an explanation for the death, then any co-factor that increases agitation or induces additional stress should exacerbate the mechanisms leading to death.
- ***Dr. Butt*** – agreed with the suggestion that Mr. Dziekanski's state of agitation, the fact that the conducted energy weapon had been deployed against him, and being wrestled with and struggling on the ground were all triggering causes of death in the sense that they increased his heart and respiration rates, adding to his stress and causing the release of adrenaline. Absent the weapon and physical restraint, Mr. Dziekanski would have survived.
- ***Dr. Swerdlow*** – said that both sympathetic nervous stimulation and stress-related hormones (catecholamines) could directly affect the heart. They can make the heart beat faster, and in vulnerable individuals they can cause ventricular tachycardia and fibrillation. He agreed that any stressful situation can increase sympathetic nervous

system activity, and it is reasonable to assume that a physical confrontation with law enforcement may produce a hyperadrenergic state. In his view, it was reasonable to postulate that Mr. Dziekanski had a hyperadrenergic state during (and prior to) his confrontation with the RCMP. However, neither postulate could be proved, nor was it possible to determine the relative contributions of the conducted energy weapon discharges and the other factors to this hyperadrenergic state.

- ***Dr. Kerr*** – said that in a "fight or flight" situation, the brain stimulation results in adrenaline surging directly down the sympathetic nervous system. In addition, hormones in the bloodstream (i.e., catecholamines) act on those nerve fibres in the heart and directly on the cells of the heart. In cases of very intense stimulation, the adrenergic state gets progressively higher and starts to push the heart to tremendous degrees. The recipient of a conducted energy weapon discharge is getting an intensely painful stimulation. There would be no question that the level of sympathetic stimulation in this case would have been astronomically high, and it would stimulate the heart to beat excessively rapidly. It is hard to escape the conclusion that the weapon applications contributed as a major cause of Mr. Dziekanski's death.
- ***Dr. Tseng*** – agreed that one of the theories of how "sudden death during restraint" occurs is that stress from a heightened adrenergic state causes an arrhythmia of the heart. Any deployment of a conducted energy weapon, whether in probe or push-stun mode, would create intense pain, which itself would lead to an increased adrenaline state.
- ***Dr. Sloane*** – said that Mr. Dziekanski was alert, but confused and sweaty. He appeared to be in a state of agitated delirium, which could be consistent with or exacerbated by a state of alcohol withdrawal. In such a state, one would expect him to be in a state of adrenergic excess, which could increase the likelihood of him suffering from the sudden in-custody death syndrome.
- ***Dr. Ho*** – agreed with Dr. Lee that Mr. Dziekanski's sudden death during restraint was likely due to a variety of factors, including his underlying disease processes secondary to alcohol abuse and his volitionally elevated state of metabolic demand.
- ***Dr. Lu*** – said that Mr. Dziekanski's laboured breathing is often a sign either of dehydration or autonomic instability, the latter of which refers to physiological changes in the body where there is increased heart rate, blood pressure, and respiratory rate. He agreed with Dr. Kerr's opinions respecting a hyperadrenergic state.

- ***Dr. Chambers*** – said that Mr. Dziekanski was, because of stress and exhaustion, in a hyperadrenergic state even before his interaction with the RCMP officers. The mechanisms by which the stress of physical restraint can trigger sudden death involve activation of the "fight or flight" response. Adrenaline, cortisol, noradrenaline, and other neurohormones are released, causing increases in blood pressure, the heart rate, the metabolic rate, and blood sugar. The heart becomes more vulnerable to fatal cardiac arrhythmias. This mechanism would also apply to the response to stress caused by deployment of a conducted energy weapon, driven by the extreme pain and muscle feedback to the brain via spinal cord pathways due to effects of repeated discharges. The associated anxiety from the weapon discharges and the immobility would certainly have caused a severe "fight or flight" response.

There is another dimension to this hyperadrenergic effect – acidosis – that should be considered. In his written report, Dr. Swerdlow concluded that several factors probably contributed to Mr. Dziekanski's cardiac arrest, including respiratory acidosis and possibly metabolic acidosis. In his testimony, he explained that respiratory acidosis develops when metabolic activity results in a build-up of carbon dioxide, but the body is unable to exhale it because of a cessation of breathing. The carbon dioxide builds up in the blood as carbonic acid, and cellular mechanisms, including cardiac contraction, work less well and the subject can die.

In the case of metabolic acidosis, lactic acid is generated when muscles work very hard and do not get sufficient oxygen transported to them. Normally a body gets rid of lactic acid by transporting it to the liver, where it is converted into carbonic acid, which is the acid that the lungs can then breathe out as carbon dioxide. However, if the person has liver disease, it will take longer for the liver to convert the lactic acid to carbonic acid. In addition, if the person is not breathing well, the potential for being acidotic is greater.

Dr. Ho said that Mr. Dziekanski's underlying condition of metabolic acidosis should not be underestimated – this condition is known to be an associated risk for a sudden death event. He added that the evidence of Mr. Dziekanski being agitated and showing signs of exertion is consistent with his own recent research that found 45 seconds of vigorous exertion is enough to make a person really ill from a metabolic acidosis standpoint. The heart, which initially beats very fast to compensate for the acidosis, eventually slows down and then heart function stops, with a presenting rhythm of asystole or pulseless electrical activity.

Having regard to all the evidence, I am satisfied that the hyperadrenergic response, which was significantly exacerbated by Mr. Dziekanski's interaction with the RCMP officers, is the most likely cause of Mr. Dziekanski's death. It may be that acidosis played a part as well.

Mr. Dziekanski's interaction with the RCMP consisted of the multiple deployments of the conducted energy weapon and the physical altercation on the floor that culminated in Mr. Dziekanski being handcuffed. While there was consensus among the medical experts that the physical altercation exacerbated the hyperadrenergic response, several medical experts did not agree that the conducted energy weapon was a contributing factor. For example:

- ***Dr. Di Maio*** said that there was no evidence that the weapon caused the death, but he appears to have limited his analysis to direct capture of the heart by electrocution.
- ***Dr. Swerdlow*** was more equivocal. He stated that the postulated hyperadrenergic state could not be proved, and in any event it is not possible to determine the relative contributions of the weapon discharge and other factors (e.g., the physical altercation) to the hyperadrenergic state, or to determine the relationship between that state and the mechanism of death. I accept that this hyperadrenergic state cannot be proved, but I stated earlier that it is not possible in this case to determine the cause of Mr. Dziekanski's death with an absolute certainty. Given the negative autopsy findings, we are left to draw inferences from the evidence we do have and develop a logical rationale for the most likely cause of death.
- ***Dr. Ho*** said, in his concluding opinion that to a reasonable degree of medical certainty or probability, the conducted energy weapon did not cause or contribute to Mr. Dziekanski's death. However, in the body of his report he repeatedly referred to Mr. Dziekanski's medical conditions and activities that placed him at significant risk for sudden cardiac death, and then added that all of these "were independent of the application of the [conducted energy weapon]." In my view, whether any one of those medical conditions or activities could have, standing alone, caused a fatal cardiac arrhythmia misses the point. The fact is

> that none of them had, prior to the intervention of the four RCMP officers, triggered a fatal arrhythmia, and yet within 25 seconds of the weapon discharges and physical altercation, he had gone into cardiac arrest. It is singularly unhelpful, in such circumstances, to suggest that the physical altercation could have caused the death independent of the conducted energy weapon, thereby avoiding the obvious question, "Did the conducted energy weapon contribute to the death as well?"

In my view, it would defy common sense to conclude from all the evidence that the physical altercation exacerbated the hyperadrenergic state that led to Mr. Dziekanski's fatal cardiac arrhythmia, but that the multiple deployments of the conducted energy weapon played no part. To the extent that Dr. Ho did so, I do not accept his evidence. It is beyond dispute that a single five-second deployment of the weapon causes intense, extreme pain, as well as emotional trauma. Multiple deployments, even if intermittent, must compound that pain and trauma.

In my view, it would be insulting to the intelligence of any objective and thoughtful person who sat through our evidentiary hearings and viewed the Pritchard video to baldly assert that the physical altercation, but not the multiple deployments of the conducted energy weapon, was responsible for the hyperadrenergic state that led to Mr. Dziekanski's fatal cardiac arrhythmia.

The final issue to address is whether it is possible to articulate how much the weapon and the physical altercation contributed to Mr. Dziekanski's death. My understanding of the medical evidence is that a variety of elements can combine to produce this type of fatal hyperadrenergic state, including physical pain, emotional stress, fear, physical struggling, and exhaustion.

The Pritchard video is a valuable source of information about the effect that the weapon and the physical altercation had on Mr. Dziekanski. Any objective viewer will shudder at his screams of agony when the weapon was first deployed and when, during the second deployment, he "turtled" around in a circle on the floor, clutching his chest and groaning – all this before the officers moved in and initiated physical contact. Mr. Dziekanski's sounds were more muted during the physical altercation, but there is no question that having his arms brought behind his back and being handcuffed was an enormous exertion for Mr. Dziekanski.

Dr. Chambers said that the Pritchard video assisted him in assessing the relative impact of physical restraint and the conducted energy weapon in contributing to Mr. Dziekanski's electrical death. In his view, the weapon had a far more violent effect. His outward response to physical restraint appears to be significantly less violent and reactive. To a similar effect, Dr. Kerr said that it is hard to escape the conclusion that the conducted energy weapon applications contributed as a major cause of Mr. Dziekanski's death.

The evidence does not allow me to conclude, with mathematical exactitude, how much the weapon and the physical altercation contributed to the hyperadrenergic state that led, ultimately, to Mr. Dziekanski's death. Unquestionably, they both contributed substantially to that tragic result. However, I consider it to be a reasonable inference to be drawn from all the evidence that the multiple deployments of the conducted energy weapon played a more prominent role.

4. Concluding comment

This part of the report has been, of necessity, a detailed forensic examination of the medical conditions and/or mechanisms that most likely caused Mr. Dziekanski's untimely and unnecessary death. While ascertaining the medical cause of Mr. Dziekanski's death may satisfy the intellect, there is a human dimension to this story that ought not to be ignored.

It is a story of high hopes, new beginnings, dashed dreams, and tragic loss. What did Mr. Dziekanski think and feel during the last minutes of his life? His last recorded words, "Have you lost your minds?" or "Have you gone insane? Why?" spoken as Cst. Millington was deploying what looked like a pistol against him, convey a sense of incredulity, fear, and panic at the prospect of being shot.

When the details of Mr. Dziekanski's last minutes first came to light, many people asked, "Why did this have to happen?" Although we now know much more about what happened and about the medical mechanism leading to his death, that haunting pivotal question still remains, "Why?"

PART 8

THE RCMP'S MEDIA RESPONSE TO MR. DZIEKANSKI'S DEATH

PART 8: THE RCMP'S MEDIA RESPONSE TO MR. DZIEKANSKI'S DEATH

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A. INTRODUCTION

In this part, I will discuss some aspects of the RCMP's response to Mr. Dziekanski's death – in particular, the information its officers released to the public about what had transpired at the Vancouver International Airport.

I am satisfied that my Terms of Reference are broad enough to cover these activities. Paragraph 4(2)(b) instructs me "to make a complete report of the events and circumstances of and relating to Mr. Dziekanski's death, not limited to the actual cause of death." In my view, these activities are "events ... relating to Mr. Dziekanski's death."

However, I do not believe that my mandate extends to an examination of the investigation carried out by the RCMP's Integrated Homicide Investigation Team into whether anyone should be charged with a criminal offence arising out of these events. I would have required much more specific authorization to embark on such an inquiry.

B. THE RCMP'S PUBLIC STATEMENTS ABOUT THE EVENT

1. Sergeant Pierre Lemaitre

a. His initial briefing and media interviews

In October 2007 Sgt. **Pierre Lemaitre** was acting non-commissioned officer-in-charge of Strategic Communications for the RCMP in British Columbia. He was the senior media relations officer for the entire province. The purpose of the media program is, in his words:

> [T]o get the facts, information that we have out to the public, and that's usually via the media, be it print, television or radio. We try to be proactive in our media releases to keep the public informed. We have a fairly up-to-date media website that we use to get that information out.[266]

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[266] Transcript, April 21, 2009, p. 30.

According to Sgt. Lemaitre, at approximately 4:30 a.m. on Sunday, October 14, 2007, he received a phone call from Cpl. Dale Carr of the RCMP's Integrated Homicide Investigation Team (IHIT). IHIT is a team of RCMP officers who investigate all homicides and in-custody deaths arising in areas policed by the RCMP, as well as in several Lower Mainland municipalities policed by municipal police forces. Cpl. Carr was the official spokesperson for IHIT.

Cpl. Carr told Sgt. Lemaitre that there had been an incident at the Vancouver International Airport in which a man causing a disturbance had had a confrontation with some RCMP officers, a conducted energy weapon had been used, and the man had died. Although normally IHIT would handle media relations, Cpl. Carr asked Sgt. Lemaitre to become involved because there would be international interest in this event and because Sgt. Lemaitre was bilingual. Sgt. Lemaitre agreed to meet him at the RCMP detachment.

They met at 6:30 a.m., and Cpl. Carr took Sgt. Lemaitre to a briefing room in the detachment building, where about a dozen IHIT officers were working on laptops. Cpl. Robinson was one of the officers there. Sgt. Lemaitre asked Cpl. Carr what he wanted him to report publicly. Cpl. Carr told him what information he had cleared with his superiors that could be released, which Sgt. Lemaitre summarized for me as follows:

> Q So what were you being instructed factually by Corporal Carr?
>
> A That a man of unknown origin had caused a disturbance in the waiting area at YVR. He had entered past some glass doors; he had been banging on glass; had thrown a computer to the ground. Members arrived, they attempted to calm him down, communicate with him, and at some point they deployed their TASER, struggled with him, and as we now know, the man unfortunately passed away.[267]

Sgt. Lemaitre also viewed on a laptop computer about one minute of the Pritchard video: "The sequence that I can recall is the sequence where Mr. Dziekanski is

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[267] Transcript, April 21, 2009, p. 36.

TASERed, and what I saw were three members struggling with him."[268] After about 45 minutes the two of them left, in separate cars, for the Airport, where Sgt. Lemaitre had several interviews with the media.

Sgt. Lemaitre told me that he believed that Cpl. Carr was the sole source of all the information about the event that he used for his news release and during media interviews. He did not speak to any of the RCMP officers involved or to any of the other IHIT investigators. He had no recollection of Cpl. Robinson or any of the IHIT officers (other than Cpl. Carr) providing him with a briefing at the detachment.

b. His written news release

After the media briefing at the Airport, Sgt. Lemaitre prepared a written news release, which he posted on the RCMP's website.[269] It states in part:

> At approximately 1:28 a.m. RCMP officers who work at YVR were called because a man in his 40's was in the international arrival area at Vancouver International Airport. He was sweating profusely, behaving irrationally, throwing chairs, tipping his luggage cart over, pounding on glass windows, and yelling. The security personnel at YVR attempted to have a dialogue with this man, to no avail. He grabbed a computer off a desk and threw it to the ground. Then they called the RCMP.
>
> Three officers attempted to speak with the man, who continued to ignore their commands. The male remained violent and agitated. When [he] attempted to grab something off a desk, the RCMP member used the conducted energy weapon (TASER) in order to immobilize the violent man. The man fell down but continued to flail and fight. The officers then held the man down on the ground and placed handcuffs on him. He continued to be combative, kicking and screaming. He then became unconscious. His vital signs were monitored while waiting for emergency medical personnel. EMS arrived and continued to monitor and provide aid to the male. Moments later, he died.

c. His subsequent media interviews

On October 15 and 16, Sgt. Lemaitre gave further English-language interviews and, subsequently, a French-language TV interview with Radio-Canada. In all these interviews, he relied on the information that Cpl. Carr had initially given to him. He had received no other details of the incident and had viewed about one minute of the Pritchard video only once. Several statements in these interviews are noteworthy:

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[268] Transcript, April 21, 2009, p. 34.

[269] Exhibit 98. Supt. Rideout told me that in his view Sgt. Lemaitre's October 14 written news release contained far too much detailed information for that early in the investigation.

- ***October 15 with CTV*** – Sgt. Lemaitre stated that "chairs were flying," that the "violence was escalating," and that Mr. Dziekanski was "combative." He told me that he must have obtained these descriptions from Cpl. Carr, who was his sole source of information.
- ***October 16 with CBC*** – in response to a witness's statement to the media (Ms. Ashrafinia) that the conducted energy weapon had been deployed against Mr. Dziekanski four times, Sgt. Lemaitre stated: "I can go again on record and tell you that that is incorrect.... So he was TASERed twice with the same conducted energy weapon."[270] This assertion is inconsistent with Cpl. Millington's notes, made early in the morning of October 14, to the effect that he deployed the weapon four times. Sgt. Lemaitre told me that he was not aware of this information when he gave this interview. However, when he later learned the true number of times that it had been deployed, he would have loved to correct the public record, but by then Cpl. Carr of IHIT was in charge of media relations for this investigation: "[I]t was not my place nor my role to either demand or to independently go to the media and correct my past statements."[271]

During the same interview, Sgt. Lemaitre was asked whether there was a video of the incident at the airport:

Q	Given that the world [indecipherable] cams all over the place, is there airport video that's been reviewed as well?
A	Very interesting question. That was probably the first or second question our IHIT investigators asked for when they arrived at the airport. I can tell you that there was no video camera in that area at the airport.[272]

He told me that what he meant was that there was no closed-circuit video of the secure area, which was true. However, although he knew of the existence of the Pritchard video, he did not make any reference to it. He stated:

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[270] Exhibit 132, p. 3.

[271] Transcript, April 21, 2009, p. 45.

[272] Exhibit 132, p. 7. Sgt. Lemaitre made a similar statement during a CTV interview: Exhibit 131, Disc C.

> Q But in the course of answering that, you made no mention on that interview of the existence of the Pritchard video.
>
> A Again as I mentioned earlier in discussions with you, there is certain information that's cleared to release to the public, and when the investigators give you that information, that's what you go with. Again, I was aware of the existence of this video, so it's part of the greater investigation. So I am confident that in time when they deem it appropriate that, you know, that's part of the evidence of the investigation.
>
> Q Okay. Did someone tell you not to disclose the fact that there was a Pritchard video?
>
> A No, sir.[273]

d. Transfer of media responsibilities to Cpl. Carr

Sgt. Lemaitre told me that after his October 16 interviews, responsibility for RCMP media relations was transferred to Cpl. Carr, a member of IHIT. Sgt. Lemaitre was confident that Cpl. Carr would release updated information in a timely manner. When it became publicly known that some of the information he had released was incorrect, the media criticized him. He was anxious to set the record straight and had discussions with communication strategists who he worked with, as well as some pretty animated discussions with his superior, Staff Sgt. John Ward. He accepted that in homicide investigations IHIT is in control and calls the shots, and that he had to have faith that in time the information was going to come out.

Sgt. Lemaitre acknowledged that when he was interviewed in French in November 2007 by Radio-Canada about another matter, a question came up about the Dziekanski matter. He took the opportunity to set the record straight and inform the public that he had misrepresented the facts in his October interviews, but that Cpl. Carr had subsequently corrected some of the inaccuracies. He would have done the same in an English-language interview if a reporter had raised the issue, but it was not up to him to call a press conference to do so.

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[273] Transcript, April 21, 2009, p. 46.

2. Corporal Dale Carr

a. The briefing at the Richmond RCMP detachment

Cpl. **Dale Carr** was transferred to IHIT as an investigator in September 2006 and took on full-time media relations for IHIT in January 2007. Several years earlier he had completed a one-week media relations training program at "E" Division Headquarters in Vancouver.

Staff Sgt. Attew, the team leader in this investigation, alerted him to the Dziekanski incident at about 2:00 or 2:30 a.m. on Sunday, October 14. Cpl. Carr soon realized the media interest that would develop over an in-custody death at an international airport after the RCMP had deployed a conducted energy weapon. On his way to the Airport, he decided that this was not a routine IHIT incident, but was one that had a divisional (i.e., provincial) significance. For that reason, he phoned Sgt. Lemaitre and advised him of the incident, and they agreed to meet in Richmond. The fact that Sgt. Lemaitre was bilingual was an additional, but not the principal, factor in involving him.

Cpl. Carr went first to the International Arrivals area of the terminal, to get a good mental picture of the scene of the incident. He then went to the RCMP's Airport detachment, mistakenly believing that the IHIT team would be working out of that facility. He then drove to the Richmond RCMP detachment and went into the command centre that members of IHIT were setting up.

At 7:23 a.m. a briefing began. With respect to Cpl. Robinson's involvement in the briefing, Cpl. Carr told me:

> I don't recall if he spoke to the entire room or if – I recall him coming in, speaking to one individual. That's my recollection, and I don't recall if he actually addressed the entire room with the incident, or if somebody else did that. I would have been sitting at a table basically taking notes and just listening. I didn't really pay much attention to who was actually speaking, and I didn't make note of it either.[274]

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[274] Transcript, April 22, 2009, p. 13.

The notes he took of the briefing[275] state in their entirety:

- Throwing stuff around @ Info Booth
- Male agitated
- Grabbed computer
- YVR Security attempted to intervene
- Police RCMP arrived (four mbrs)
- Swinging article @ mbrs
- Mbrs attempt to control verbally
- Non-compliance
- CEW used
- once on ground continue to fight
- Monitored – Security with First Aid
- 4 Sep vehicles – 4 mbrs attend

Cpl. Carr was not sure whether Sgt. Lemaitre attended the briefing. Cpl. Carr watched the Pritchard video twice. The first viewing was on a very small screen (perhaps Mr. Pritchard's camera), up to the point when Mr. Dziekanski fell to the ground. The second viewing, with Sgt. Lemaitre for about a minute, was on a laptop. Cpl. Carr confirmed with Staff Sgt. Attew that they were authorized to release the information contained in his notes.

He told me that he and Sgt. Lemaitre discussed strategy on how they should handle this incident. "Based on some experiences we've had in the past, we thought that it would be best to get as much information out about the incident as we could in a timely manner so that that information is out there and then shared with the community."[276] They then left for the Airport to meet the media.

b. The media interviews at the Airport

Sgt. Lemaitre was the lead spokesperson, and conducted four interviews at various venues at the Airport. Each interview took about 15-20 minutes. Cpl. Carr was standing near Sgt. Lemaitre, but was not paying much attention to what was being said, as he was handling numerous calls from reporters and facilitating other interviews.

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[275] Exhibit 99.

[276] Transcript, April 22, 2009, p. 16.

Cpl. Carr acknowledged that he later became aware that some of the information released by Sgt. Lemaitre during the media interviews (e.g., the number of weapon deployments) was inaccurate. He told me that he could not be certain that he gave such information to Sgt. Lemaitre, because it is not in his notes, and it is possible that this was information that they heard during the briefing. With respect to Sgt. Lemaitre's non-disclosure of the existence of the Pritchard video, Cpl. Carr told me: "It was evidence, police evidence in an investigation. I very commonly never talk about all of our evidence that we have gathered.... Unless it was asked of us directly, we're not going to talk about that type of thing."[277]

He acknowledged that he learned a lot from this experience, such as not to be in such a hurry to meet deadlines imposed by the media. Since then, he sets out on paper the information he intends to release to the media, has the team leader review it, and then sticks to the script during interviews.

c. *Transfer of media relations to IHIT*

On October 16, Cpl. Carr and Sgt. Lemaitre attended a meeting at "E" Division Headquarters with Superintendent Wayne Rideout (the officer in charge of IHIT) and an employee from the "E" Division media office. Supt. Rideout decided that IHIT would take back media relations in the Dziekanski matter, for two reasons. First, it was impractical to have Sgt. Lemaitre, based in Vancouver, handle media relations for IHIT, based in Surrey. Second, Supt. Rideout wanted to stop all communication of *evidence* out to the community and limit media relations to matters of *process*.

On October 30, 2007, Cpl. Carr issued a media advisory explaining why the RCMP was not willing to release the Pritchard video at that time – it was vital evidence and its release could compromise the investigators' goal of conducting a fair and unbiased investigation. There were still some witnesses who had not yet been interviewed, and investigators were concerned that release of the video would compromise what those witnesses had to offer. He explained to me:

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[277] Transcript, April 22, 2009, p. 28.

> [O]ur goal as investigators is to get what a person saw and not what they're told. By releasing that video to the community, we're essentially telling them what they're seeing, and it could change, in their mind, what they saw.[278]

Cpl. Carr told me that in the weeks after the incident, he took steps to attempt to correct the misinformation that had been provided to the public. However, Supt. Rideout instructed him not to do so. The information would be corrected eventually, but while the investigation was in fact-finding mode they were not going to release and speak about the evidence.

Cpl. Carr was referred to his November 30, 2007, press release, which challenged the perception that the RCMP officers did not administer first aid to Mr. Dziekanski after deployment of the conducted energy weapon. When it was suggested to him that this was an example of the RCMP speaking about the facts of the case, not just process, he stated:

> A Well, I can tell you that based on some consideration, careful consideration over whether to respond to the fire department's accusation that we did absolutely nothing, which was our belief that that was not the case, it was reviewed and it was felt – and approved by Superintendent Rideout that I could go ahead and speak to that individual piece of information.
>
> Q So the superintendent's directive to you around October the 16th wasn't a hard and fast rule, was it?
> A Well, it was his instructions to me that we would stick to process and not talk about the evidence. From time to time that was reviewed for certain instances, I suppose.[279]

d. The RCMP apology

On April 22, 2009, immediately before Cpl. Carr testified at our evidentiary hearings, RCMP Sgt. Tim Shields, the officer in charge of Strategic Communications for

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[278] Transcript, April 22, 2009, p. 31.
[279] Transcript, April 22, 2009, p. 64.

"E" Division, made a statement to the media outside our hearing room, apologizing to the public about how the media relations were handled in the Dziekanski matter. Cpl. Carr was asked whether he also was of the opinion that an apology to the public was in order. He responded:

> I'm certainly sorry that – absolutely sorry that misinformation got portrayed and we're here today to try and sort that out. Absolutely. It's never been my intention, ever, ever, to mislead the public. I'm not a liar. I don't intend to lie to anybody ever, and absolutely I'm sorry that this has gotten to the point that it is today.[280]

3. Superintendent Wayne Rideout

a. The decision to postpone correcting inaccurate information

In October 2007 Supt. Rideout was the officer in charge of the RCMP's Integrated Homicide Investigation Team, based in Surrey, BC, and in mid-November he took charge of this investigation as team commander. He told me that it was at his direction that IHIT took back media relations in the Dziekanski case on October 16, primarily to ensure that disclosures to the media were limited to matters of process, not evidence. He was aware that by then the media had been provided with some incorrect information, but he made the decision not to correct that information at that time. His primary goal was to conduct an independent investigation into Mr. Dziekanski's death, culminating in a brief to Crown Counsel. He appreciated the media's hunger for information, but at the same time had a duty to guard evidence, adding:

> So we find ourselves in a somewhat of a difficult position. Again we can be criticized for lack of information, but we can be equally criticized for providing too much information, particularly when it comes to evidence.[281]

By way of example, Supt. Rideout referred to Sgt. Lemaitre's initial public statement that the conducted energy weapon had been deployed against Mr. Dziekanski twice. Supt. Rideout learned on October 31, 2007, that the weapon had been discharged five times, for a total of 31 seconds. In his view, this evidence went to the heart of IHIT investigation:

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[280] Transcript, April 22, 2009, p. 75.

[281] Transcript, May 6, 2009, p. 6.

> My point is this, is that the – the number of cycles, whether the application of those cycles, whether they were in contact or not, whether the use of force was justified or not and what the cause of death were, were highly relevant to the criminal prosecution and the decision on criminal charges. Therefore my decision was that it was – the actual number and the issues pertaining to the application of the device were central to any potential criminal prosecution and there was no way to provide that information without getting into lengthy media debates on that, potentially damaging any criminal prosecution.[282]

Even at the end of 2007, when most potential witnesses had been interviewed, Supt. Rideout was still unwilling to speak to the media about evidence. He told me that they had not yet received the pathology report or the use-of-force report, and officers were still investigating Mr. Dziekanski's state of health. He was concerned about the impact of leaving incorrect information in the public domain, but in reference to a series of e-mails he sent or received during this time period, he added:

> And as you review the e-mails, you see it was – you'll see it's a common thread of discussion and concern and a recognition of the need, that that information needed to get it back out into the public at the earliest possible opportunity. But again that always remained a balance between the need to gather all the evidence and potentially present it to a criminal court.[283]

As to whether he took directions from his superiors on this issue, he was equally adamant:

> I made the decision and I advised my superiors, sir. Certainly there was consultation. There was discussion in general terms about what types of things would be in the media. But as the major case manager, as the team commander, it was ultimately my decision to guard evidence.[284]

Supt. Rideout said that with the benefit of hindsight, it would have been preferable for him in November 2007 to have issued a statement to the effect that he was aware that incorrect statements had been made to the media, but that he would discuss neither the nature of what they were nor the evidence as the investigation proceeded.

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[282] Transcript, May 6, 2009, pp. 6-7.

[283] Transcript, May 6, 2009, p. 13. The e-mails are found at Exhibit 138.

[284] Transcript, May 6, 2009, p. 7.

b. The return of the Pritchard video to Mr. Pritchard

Supt. Rideout told me that the Pritchard video was highly valuable to this investigation. "There's no question it provided, if you will, the anchor from which this investigation based its findings."[285] In his view it was critical to interview all witnesses who had observed the incident, before the video was returned to Mr. Pritchard:

> It was extremely important to us to interview witnesses who were present and observed the event in real time, and their recollections were fresh and true based on their memory, rather than what they would have reviewed on TV through the video.[286]

He explained that IHIT retained possession of the Pritchard video (in spite of Mr. Pritchard's initiation of legal proceedings to recover possession) under the authority of the *Coroners Act*, at the request of the coroner. However, on October 31, 2007, Supt. Rideout drafted an e-mail that stated in part, "Yesterday the coroner in contradiction to his request of last week sent IHIT a letter indicating they took no issue with the release of the video and it should not be held under the *Coroners Act*."[287] Supt. Rideout told me that the only other legal justification for retaining the video would be under the *Criminal Code*, but that would require satisfying a justice that IHIT was investigating an actual criminal offence. At this stage, they were investigating only for the purpose of determining if a criminal offence had occurred.

In anticipation of the return of the video to Mr. Pritchard and its likely release to the media (which happened on November 7, 2007), Supt. Rideout confirmed in an e-mail to his superiors that !HIT would maintain its position of not discussing evidence in public. He agreed that the team was faced with a difficult and embarrassing situation, and was between a rock and a hard place, adding:

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[285] Transcript, May 6, 2009, p. 16.

[286] Transcript, May 6, 2009, p. 16.

[287] Exhibit 138, p. 2.

> We are the police; we are a police organization investigating the actions of the police. Obviously that is the subject of much debate and sometimes criticism, as are the public releases made by the police while investigating the police. Our position is that it's extremely difficult as the investigative body to speak about the event and the specifics of the event, without appearing to be biased. As we get into evidence, we inherently are drawn into a discussion or debate about the evidence that we cannot participate in as the investigative body, and that's the purpose of that statement. So we are criticized if we release information, and we're criticized when we do not.[288]

c. *Challenging firefighters' suggestions that Mr. Dziekanski had stopped breathing*

Supt. Rideout was referred to a November 28, 2007, e-mail he received from a superior,[289] indicating that the Richmond Fire Department would soon be replying to a freedom of information request for release of its Fire-Rescue incident report. Supt. Rideout believed that the contents of the incident report would question whether Mr. Dziekanski was breathing when the firefighters arrived, with the likely resulting media posture that the four RCMP officers simply stood by and did nothing. He told me that he authorized Cpl. Carr to publish a news release on November 30 challenging such suggestions, although he recognized that discussing the evidence in this way was inconsistent with his earlier decision that disclosures to the media should be limited to matters of process. However, he said that he considered it appropriate to discuss this aspect of the evidence in public because by then IHIT had gathered all relevant evidence on this issue, which showed that there was a pulse and there were sounds of breath for the eight minutes before the arrival of the ambulance.

Supt. Rideout disputed the suggestion that IHIT was in a conflict of interest for investigating fellow officers but at the same time issuing news releases explaining their actions. He stated:

> I don't agree, sir, that we were in a conflict of interest. I agree, I would state that what we were in was in a very difficult position with respect to public relations for the RCMP, but we chose, and the RCMP supported a position,

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[288] Transcript, May 6, 2009, p. 25.

[289] Exhibit 138, p. 53.

> which was to maintain the integrity of process and investigation at the expense of its own public relations.[290]

C. FINDINGS OF FACT AND CONCLUSIONS

1. Introductory comments

Before making any findings of fact or reaching any conclusions respecting the RCMP's media response to Mr. Dziekanski's death, I gave careful consideration to the written and oral closing submissions of counsel for the participants. I would like to comment briefly on two of those submissions:

- whether the Terms of Reference for this Commission of Inquiry authorize me to inquire into the RCMP's post-death media relations activities and public statements; and
- whether a provincially established Commission of Inquiry is constitutionally authorized to inquire into the conduct of individual RCMP officers who played a role in the media response and, if I consider it appropriate to do so, make findings of misconduct against any of them or against the RCMP itself.

With respect to the Terms of Reference issue, it was clearly the intention of the provincial government that this be a wide-ranging inquiry,[291] and I have been specifically directed "to make a complete report of the events and circumstances of and relating to Mr. Dziekanski's death, not limited to the actual cause of death." I took the position throughout the Inquiry's proceedings that this was not an inquiry into the Integrated Homicide Investigation Team's criminal investigation into whether anyone should be charged criminally arising out of the Dziekanski incident. However, that does not mean that I should not inquire into any post-death matters.

In much the same way that it was proper for me to make what turned out to be exhaustive inquiries into the medical cause of Mr. Dziekanski's death, it was in my view equally proper to address how the RCMP and its officers initially portrayed the incident to the public.[292] I consider the RCMP's media response to be a continuation of the chronology, falling within the wording of the Terms of Reference; that is, "the events and circumstances of and relating to Mr. Dziekanski's death." Further, there was an intensely negative public reaction to the RCMP's media response, which in my view had the potential to undermine public confidence in the RCMP. When public confidence in such an important institution (that polices more than half of our province) is brought into question, it is in my view one of the principal functions of a public inquiry to address that issue and report to the government and public on it.

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[290] Transcript, May 6, 2009, p. 46.

[291] See *Hansard*, November 19, 2007, p. 9261*ff*.

With respect to the constitutional issue, I am satisfied that the inquiries I have made and the findings and conclusions set out below are within the jurisdiction of a provincially established Commission of Inquiry. Even applying the strict test articulated by the Supreme Court of Canada several decades ago,[293] my inquiries into the RCMP's media response were inquiries into the *conduct* of specific officers during the performance of their duties. While I was referred to some of the RCMP's policies in the context of my analysis of the conduct of those officers, I was not conducting an inquiry into those policies themselves or their adequacy, let alone making recommendations for reforms to them.

2. The factors responsible for the RCMP's regrettable media response

It is not in dispute that some of the RCMP's public disclosures about the Dziekanski incident, during the early stages of the criminal investigation, were factually inaccurate.

When the RCMP became aware of these inaccuracies, they decided not to correct them, choosing instead to limit their public statements to matters of process, not evidence.

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[292] I ruled to that effect on May 4, 2009, at p. 10.

[293] See, for example, *Attorney General of Quebec and Keable v. Attorney General of Canada et al.*, [1978] 1 S.C.R. 218 (Supreme Court of Canada).

This poorly managed media response to Mr. Dziekanski's death was widely reported and generated negative comment in the media, culminating in an official RCMP apology.

In my view, there were several factors that were principally responsible for this regrettable media response – the rush to publish, the failure to correct inaccuracies, and a conflict of interest.

a. The rush to publish

In one sense, I was impressed with Cpl. Carr's and Sgt. Lemaitre's exceptionally prompt response. Within a few hours of Mr. Dziekanski's death, they had been briefed by the IHIT investigators and were providing interviews to the media at the Airport. They did so in pursuit of the RCMP's well-intentioned desire to inform the public and the media about its criminal investigations and to provide updates as those investigations progress.

But that desire for transparency and responsiveness came at a cost. The investigation was just getting off the ground, and these media relations officers were dealing with preliminary, unsubstantiated information. This led to Sgt. Lemaitre disclosing factually inaccurate information about the behaviours of Mr. Dziekanski, the response of the officers, and the number of times the conducted energy weapon was discharged. I am satisfied that he did not know at that time that some of the information he was disclosing was inaccurate.

In my view, a well-intentioned desire to inform the public about what had happened at the Airport pre-empted the equally important goal of accuracy. It may have been appropriate to make a brief public statement to the effect that an arriving international passenger had died at the Vancouver International Airport following an incident with RCMP officers responding to a disturbance call. However, delving into greater detail ran the risk that subsequently discovered facts might contradict these early pronouncements. While I do not fault Sgt. Lemaitre for conveying to the public information about the incident that had been approved for release, in hindsight, it would have been preferable to avoid any detailed discussion of the circumstances at that early stage in the investigation.

b. The decision not to correct inaccuracies

As more information became known about the incident, the factual inaccuracies took on more significance. They were consistently self-serving – they painted Mr. Dziekanski in an unfairly negative, and the officers in an unfairly positive, light.

Supt. Rideout prevented Sgt. Lemaitre from correcting the public record and implemented a policy of commenting publicly only on matters of process, not evidence. While this may have been an entirely appropriate policy in principle, it was problematic in this case for several reasons:

- This was not a case of keeping the public in the dark about an investigation, which sometimes is necessary to preserve the integrity of the investigation. Here, the RCMP had already published inaccurate information and, as long as it was not corrected, the public (and potential witnesses) was being misled about the true state of affairs.
- Supt. Rideout did not act consistently – in at least one instance he breached his own "process, not evidence" rule by authorizing Cpl. Carr to publicly defend their officers against allegations that they had stood around doing nothing before Richmond Fire-Rescue arrived at the scene.

I am satisfied that Supt. Rideout realized the difficult position he was in, discussed the issue with his superiors, and weighed the advantages and disadvantages of correcting the inaccuracies right away or waiting until the completion of the investigation before doing so. He had a difficult decision to make. In my view, he erred in not correcting the inaccuracies right away but his error was, at most, an error in judgement. My principal concern is that if there was RCMP-generated information in the public domain that might influence potential witnesses, better that it be *accurate* information.

With respect to the RCMP as a Force, I think it is enough to record that on April 22, 2009, outside our hearing room, the officer in charge of Strategic Communications for

"E" Division apologized for how the media relations were handled in the Dziekanski matter.

c. *The conflict of interest*

I think it is important to take several steps back and examine the factual inaccuracies in the context of the investigation as a whole. The inaccuracies include the following: that Mr. Dziekanski was combative and violent, that chairs were flying, that violence was escalating, that the conducted energy weapon was deployed against him only twice, and that he continued to be combative, kicking and screaming after being handcuffed. Based on what the investigation subsequently determined, these descriptions were inaccurate and without question they portrayed Mr. Dziekanski's behaviours as more threatening and dangerous than we now know them to have been.

The media and public reaction to these inaccurate descriptions was immediate and intense. The public's concern persuaded me that it was important for this Commission of Inquiry to examine this aspect of the RCMP's post-incident activities. The questioning of the three officers involved in the RCMP's media response was thorough and probing, and their testimony was widely reported. One could reasonably infer from this testimony and the public discussion surrounding it a suspicion in some quarters that the RCMP's handling of media relations in this incident was slanted, favouring the Force and the officers involved. Whether or not such a conclusion was justified, the fact that it existed is cause for concern. It has the potential to lessen public respect for the RCMP as a national institution, which can only undermine the capacity of its officers to effectively police our communities. That troubles me.

Most of the inaccuracies reported about this incident portrayed a participant in a disturbance as more violent than he actually was, and underreported the number of times a weapon had been deployed. If this had been a brawl outside a bar involving two intoxicated patrons, initial inaccuracies respecting one patron's behaviour or the number of times a weapon was fired would have been understood for what they were

– initial findings that were subject to change as more information became available. Why the extraordinarily different reaction here?

What makes this incident qualitatively different from my brawl example is the fact that this was a police-related death, with the RCMP assuming responsibility for conducting the criminal investigation flowing from it and for releasing information to the media and public about the incident and the investigation. It was a case of the police investigating themselves, and as so often happens in such cases, many members of the public are understandably suspicious of the investigation, regardless of how thorough and impartial it turns out to be.

The Dziekanski incident, and several other police-related deaths that have occurred recently, has generated considerable public discussion about the issue of the police investigating themselves. The issue of how, and by whom, police-related deaths should be investigated was exhaustively explored by my former judicial colleague William H. Davies, Q.C., recently in his inquiry into the death of Frank Paul.[294] His analysis of the inherent conflict of interest in a police force conducting a criminal investigation of its own members is compelling. I will have more to say about this issue, and about Mr. Davies' recommendations, in Part 10 of this report.

There can be no doubt that the controversy surrounding the RCMP's handling of media relations following Mr. Dziekanski's death is attributable to the role it played in conducting the criminal investigation. If a body at arm's length from the RCMP had conducted the criminal investigation, that body would have been, and would have been perceived by the public to be, impartial. The public would have been much more likely to accept without suspicion what such an impartial body said about the incident.

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[294] See *Alone and Cold, the Davies Commission Inquiry into the Death of Frank Paul*, February 12, 2009, available at http://www.frankpaulinquiry.ca/report/, or through the Distribution Centre Victoria (see inside front cover).

PART 9

RECENT CHANGES AT VANCOUVER INTERNATIONAL AIRPORT

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A. INTRODUCTION

Most of this report focuses on the events of October 13 and 14, 2007, that culminated in Mr. Dziekanski's death. However, the Terms of Reference also include a directive "to make recommendations the commissioner considers necessary and appropriate."

Although unlimited on its face, I have interpreted this directive in light of the overall mandate of this hearing and study commission, which is to inquire into the events and circumstances of and relating to Mr. Dziekanski's death, not limited to the actual cause of death.

Since one of the accepted purposes of a public inquiry is to prevent the recurrence of a tragedy, this instruction to make recommendations must, at a minimum, focus on improvements respecting the handling of, and services provided to, arriving international passengers at the Vancouver International Airport, especially those who do not speak English. Consequently, I have concluded that I have been instructed to inquire into the policies, procedures, and practices of those agencies at the Airport that deal with, or provide services to, arriving international passengers, specifically the Canada Border Services Agency (including Immigration and Customs) and the Vancouver Airport Authority.

In May 2009 I heard the evidence, voluntarily and not under summons, of two policy experts from the Canada Border Services Agency and one policy expert from the Vancouver Airport Authority. They explained what policies, practices, and procedures were in place in October 2007, and what changes have been implemented since then.[295] In this part, I have relied primarily on their evidence and on the printed materials they filed.

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[295] I also heard the evidence of RCMP Inspector Troy Lightfoot, the officer in charge of Use of Force and Operations Programs, in Ottawa: see Transcript, May 6, 2009, pp. 87-111. Most of his evidence related to the RCMP's evolving policy respecting use of force and, more specifically, the Force's policy respecting conducted energy weapons. I reviewed those matters in detail in the Study Commission Report, and will not do so again here.

During the evidentiary hearings I also heard evidence about three other public agencies – Richmond Fire-Rescue, the BC Ambulance Service, and E-Comm (which provides emergency dispatch services for several Lower Mainland police and fire agencies). Earlier in this report, I summarized the activities of personnel from these agencies who responded to the Dziekanski incident at the Airport. However, I do not intend to deal with those agencies in this part – in my view, an in-depth review of these agencies' policies and procedures would be beyond my mandate.

B. CANADA BORDER SERVICES AGENCY (CBSA)

1. Introduction

I am aware of the limited constitutional capacity of a provincially appointed commission of inquiry to inquire into and make recommendations respecting the internal management and administration of federally regulated agencies, such as the Canada Border Services Agency.

At the same time, it is important to remember that CBSA is often the first government agency that arriving international passengers, both tourists and immigrants, encounter. As such, CBSA is more than just an enforcement agency – it is the face of our country and of our province.

The Government of the Province of British Columbia has an interest in seeking improvements in the services that are provided to newcomers arriving here, and it is in keeping with that interest that I have undertaken this analysis of the Canada Border Services Agency.

Out of respect for my limited jurisdiction, I have attached several qualifications to the recommendations that follow. First, I limit their application to the Vancouver International Airport, as that is the only airport I have examined. If my recommendations find favour with government, it may be prudent to implement them here first, on a pilot basis.

Second, it would not be appropriate for me to direct my recommendations to the federal minister. According to convention, I have directed my recommendations to the provincial Attorney General. If the Attorney General endorses my recommendations, I invite him to urge the federal Minister of Public Safety to act on them.

I note that in his closing written submissions, counsel for the Government of Canada stated:

> Canada and its agencies are first and foremost interested in the safety and security of Canadians. Therefore, Canada will carefully review the recommendations the Commissioner considers necessary and appropriate (p. 3).

2. Policy witnesses

CBSA was formed in 2003. It was an amalgamation of three separate entities: the Customs Branch of the former Canada Customs and Revenue Agency, the enforcement arm of Citizenship and Immigration Canada, and the frontline inspection services of Agriculture Canada. It reports, through its president, to the Minister of Public Safety.

I heard the evidence of two senior CBSA officials. **Brian Hilton** is a senior policy advisor with the Arming Division in the Operations Branch in Ottawa, and **Binder Kooner** is the chief of Passenger Operations at the Vancouver International Airport. CBSA also provided documentary materials regarding training, policies, and the interpretation of legislation.

During the evidentiary hearings I had also heard the testimony of several CBSA Border Services officers, who provided insight into how CBSA policies were implemented on a day-to-day basis, and particularly during Mr. Dziekanski's time in the Customs Hall. However, these witnesses were not policy experts, and I have not relied on their testimony in the formulation of my recommendations.

In this section I will examine four CBSA policies and practices that are relevant to the manner in which Mr. Dziekanski was dealt with during his prolonged stay in the Customs Hall:

- processing passengers;
- security;
- communications between arriving passengers and greeters awaiting them; and
- interpretation services.

3. Processing passengers

As I discussed in Part 4, every arriving international passenger comes down an escalator into the Customs Hall. If the passenger has not completed the Customs Declaration Card during the flight, the passenger does so here. The passenger is directed to CBSA's Primary Inspection Line, where a Border Services officer inspects the Customs Declaration Card, and questions the passenger if further information is required. If no Customs or Immigration concerns arise, the passenger is released, retrieves any checked baggage, and exits through the Point into the public area of the Airport, after surrendering the Customs Declaration Card.

If the Border Services officer thinks the passenger is suspicious, or if the passenger's circumstances require a mandatory referral to Secondary Customs or Immigration, then the Border Services officer makes a handwritten notation on the passenger's Customs Declaration Card, and the passenger must go to the appropriate secondary area or areas. Border Services Officer Monica Kullar told me that it is mandatory to refer a passenger who does not speak English or French (such as Mr. Dziekanski) to both Secondary Customs and Secondary Immigration.[296] Mr. Hilton informed me that before any passenger is allowed to leave the Customs Hall, a Border Services officer at the Point checks the passenger's Customs Declaration Card to ensure that he or she has been cleared by Secondary Customs and/or Secondary Immigration.

Because Mr. Dziekanski disappeared within the Customs Hall area for five-and-a-quarter hours, I was interested to learn what steps CBSA takes to facilitate its processing of arriving international passengers. I was told that there are two database systems, which I will discuss in turn.

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[296] Transcripts, January 20, 2009, p. 21.

a. *Integrated Primary Inspection Line Database*

This database is used at the Primary Inspection Line and at Secondary Customs. At the Primary Inspection Line, a Border Services officer swipes a passenger's passport or other documentation through an electronic scanner, entering it into this database. If the officer refers the traveller to Secondary Customs, the officer will enter the reason for the referral into the database. When the referred traveller goes to Secondary Customs, a Border Services officer will enter the traveller's name into this database again, and the information entered at the Primary Inspection Line will appear.

This database can also be used to check if a passenger has crossed the Primary Inspection Line. However, the database does not include an alarm or warning system to notify a Border Services officer if a referred passenger fails to attend at Secondary Customs within a specified period of time. I was told that the computer system is designed for the processing of travellers, not for tracking passengers' progress through the Customs Hall.

Border Services officers in Secondary Customs are supposed to make a computer notation to indicate that they have completed processing a passenger. Thus, officers should be able to rely on the Integrated Primary Inspection Line Database to indicate whether a passenger has left Secondary Customs. However, Mr. Kooner told me that many officers do not make this notation immediately after they have finished with a passenger, waiting until the end of their shift to do so.

b. *Field Operations Support System*

This is the main computer system used for documenting immigration matters at Secondary Immigration. It also contains information about new immigrants, for example, the information about Mr. Dziekanski's sponsor (his mother) and her name and phone number. However, Mr. Hilton told me that this database does not record whether a passenger has crossed the Primary Inspection Line. That information is recorded only in the Integrated Primary Inspection Line Database, which officers at Secondary Immigration do not have access to.

Conclusions and recommendations

It is beyond my mandate to review or make recommendations about CBSA's passenger information databases generally, and I will limit my comments to those aspects of the database systems in use at the Vancouver International Airport that impacted on Mr. Dziekanski.

It is appalling that Mr. Dziekanski could have been cleared through CBSA's Primary Inspection Line efficiently, only to disappear within the cavernous Customs Hall for over five hours. No one individual appears to have been at fault for this, but CBSA's passenger tracking capability is woefully inadequate:

- CBSA still maintains two separate database systems, presumably a holdover from when Customs and Immigration were separate agencies. The net result is that Border Services officers in Secondary Customs can find out whether an arriving international passenger has cleared the Primary Inspection Line, but an officer in Secondary Immigration cannot.
- CBSA does not have the capacity to monitor a passenger's progress through the Customs Hall. Although data about each arriving passenger is entered into the Integrated Primary Inspection Line Database before the passenger clears the Primary Inspection Line, the system appears to break down at that point. There is no single database that records basic information such as whether the passenger must also go to Secondary Customs and/or Secondary Immigration, or records when the passenger arrives at and clears those secondary locations and finally passes through the Point. One database records referrals to Secondary Customs, but the other database does not record referrals to Secondary Immigration.
- CBSA offers inadequate assistance to travellers about where they must go or how to get there, especially travellers such as Mr. Dziekanski, who speak neither of Canada's official languages and are unfamiliar with air travel and airports. The officer at the Primary Inspection Line makes handwritten coded notations on the passenger's Customs Declaration Card, which the passenger cannot decipher, and tells the passenger, often in a language the passenger cannot understand, where to go. At the least, such travellers should be provided with a floor plan of the Customs Hall, identifying where Secondary Customs and Secondary Immigration are, which one or ones they must go to, and how to get there.

- CBSA makes no effort to track a passenger's progress through the Customs Hall, and to alert officers when the passenger does not reach their next "destination" within a predetermined period of time. It appears that undue reliance is placed on handwritten coded notations scribbled onto the passenger's Customs Declaration Card – an anachronism in our digital age of electronic scanners and bar codes.

Recommendation 1

I recommend that the Attorney General urge the federal Minister of Public Safety:

- To require that Border Services officers at Vancouver International Airport's Primary Inspection Line explain to each arriving international passenger, in a manner the passenger understands, whether the passenger is required to proceed to Secondary Customs and/or Secondary Immigration and, if so, how to get there.
- To implement a single integrated database system for international passengers arriving at the Vancouver International Airport that:
    - creates a file for each passenger on arrival at the Primary Inspection Line;
    - records the time when the passenger clears the Primary Inspection Line;
    - records whether the passenger is required to proceed to Secondary Customs and/or Secondary Immigration;
    - records the time by which the passenger is required to reach each Secondary location;
    - records the time when the passenger actually reaches, and subsequently clears, each Secondary location and the Point; and
    - issues an alert to all Border Services officers if a passenger does not reach the next Secondary location within a predetermined period of time.
- To impose a positive duty on specified Border Services officers to page and actively search for any passenger for whom an alert has been issued under the immediately preceding paragraph.
- Until the single integrated database system recommended above is in operation, to ensure that all Border Services officers at the Vancouver International Airport have prompt and easy access to

both the Integrated Primary Inspection Line Database and the Field Operations Support System.

4. Security in the Customs Hall

Mr. Hilton explained to me that the Vancouver Airport Authority owns the Customs Hall area and that CBSA is the tenant. As tenant, CBSA controls who enters the Customs Hall area. However, if a medical emergency or a disturbance arises, other agencies will respond, such as the Airport's Emergency Response Service, the BC Ambulance Service, the Airport's security officials, or the RCMP.

I was interested to learn what steps CBSA takes to identify and assist arriving international passengers who get "lost" or spend an inordinate amount of time in the Customs Hall area.

a. "Rovers"

Mr. Hilton told me that CBSA assigns "Rovers" to move throughout the Airport, including the Customs Hall area, to identify individuals who may be involved in the unlawful importation or exportation of goods, including illicit drugs. Their main purpose is to "engage with as many people as possible, make a quick determination as to whether they're outside ... the realm of the normal traveller, and then try to elevate the level of questions and make a decision whether they need to inspect the person further."[297]

Rovers are also on the lookout for arriving passengers who attempt to destroy their travel documents (so that Border Services officers cannot determine their country of origin or the flight they arrived on), and then claim refugee status. Rovers are not necessarily on duty at all times – it depends on the volume of passengers moving through the Customs Hall area.

It is clear that rovers perform an enforcement function, as distinct from a security or customer care function. For example, since CBSA does not have a policy prohibiting a passenger from remaining in the Customs Hall for a long period of time, a rover would not necessarily be concerned about a passenger who has been there for a long time. Both Mr. Hilton and Mr. Kooner told me that if a traveller were seen sitting in the Customs Hall, not causing a disturbance or attracting attention, the rover would not be expected to investigate.

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[297] Transcript, May 5, 2009, p. 4.

b. Surveillance cameras

In October 2007, there were 13 cameras in the Customs Hall area, with limited coverage. According to Mr. Kooner, there was modest coverage in Secondary Customs, but no coverage in the pre-Primary Inspection Line area, in the Secondary Immigration area, or in the washrooms. One Border Services officer, Trevor Gross, testified that these cameras were not necessarily monitored routinely. Mr. Kooner told me that since then, the number of cameras has increased from 13 to 97, but I understand that there is currently no policy respecting the use or monitoring of these cameras.

c. Instruction to be more vigilant

Since October 2007, all Border Services officers have been instructed to be more vigilant in ensuring that travellers move through the Customs Hall in a timely fashion. They have also been told that they may approach a passenger who has been in the Customs Hall for a prolonged period and inquire about that person's reason for being there.

Conclusions

From this evidence, I conclude that CBSA does not place a high priority on instituting programs or procedures to identify and assist arriving international passengers (like Mr. Dziekanski) who get "lost" or spend an inordinate amount of time in the Customs Hall area. While it is a positive improvement that officers are now instructed to be more vigilant to ensure that travellers move through the Customs Hall in a timely fashion, it would have been preferable to impose a mandatory duty on officers to intervene and offer assistance to travellers, rather than opting for a permissive "may approach" policy.

As I will discuss later in this part, the Vancouver Airport Authority has instituted its own program to identify and assist arriving international passengers who get "lost" or spend an inordinate amount of time in the Customs Hall area. This is a needed, and welcome, improvement, and because the Airport Authority has responded to this need, I decline to make a recommendation that CBSA do so.

5. Communication between arriving passengers and greeters awaiting them

In Part 4, I reviewed the repeated attempts by Mr. Dziekanski's mother and Mr. Hutchinson to find out from Border Services officers whether Mr. Dziekanski had arrived, only to be told that they could not disclose that information for privacy reasons.

Mr. Hilton told me that two pieces of federal legislation apply in these circumstances:

- The *Customs Act*, s. 107 prohibits CBSA from disclosing any information that it collects about a traveller, although there are several exceptions to this general rule, including that information can be released with the traveller's consent.
- The *Privacy Act* contains an overarching prohibition on the use and disclosure of personal information, except for the purpose for which it was gathered or except with the consent of the individual.

CBSA has interpreted this legislation to mean that Border Services officers may not tell an inquiring greeter whether a traveller is present in the Customs Hall, except with the traveller's consent. Mr. Hilton explained that on a national basis, CBSA has no policies specifically dealing with communications between passengers and greeters, even when the greeters are family members. However, Border Services officers are trained that they generally cannot communicate to anyone any information about an individual with whom they have dealt, without that individual's consent. They are also taught the conditions under which information about an individual may be disclosed and the uses to which it may be put. Even though the Field Operation Support System, one of the computer databases discussed earlier, contained the information that

Mr. Dziekanski's mother was his sponsor, with her name and phone number, Border Services officers would not have been authorized to discuss any information about Mr. Dziekanski with her before they dealt with him and obtained his consent.

Mr. Kooner described what happened at the Vancouver International Airport in October 2007. The CBSA office regularly received calls from greeters, attempting to locate a passenger. When a call was received about a new immigrant, a Border Services officer would look for the traveller in the Secondary Immigration area. If the traveller was present, the officer would speak to him or her, ask for consent to release the information about the traveller's whereabouts, and then pass the information on to the greeter. If the new immigrant was not present, there was no expectation that a Border Services officer would attempt to determine whether the individual had crossed the Primary Inspection Line or was in the Customs Hall.[298]

Mr. Kooner told me that, since the Dziekanski incident, CBSA at Vancouver International Airport has developed a new standard operating procedure that encourages Border Services officers to look for a traveller if more than two hours have passed since the traveller's flight arrived, and if there are extenuating circumstances:[299]

- Section 1 instructs Border Services officers to verify certain information with the greeter making the request, including the purpose of the trip, whether the traveller got on the flight, the flight number and arrival time, and if the traveller would require additional assistance. This section includes possible reasons a traveller might require additional assistance, such as if the traveller is elderly, or has medical requirements, or a physical disability.
- Section 2 directs Border Services officers to advise the greeter that routine processing can be lengthy, and to estimate a possible waiting time. This section also suggests that "[i]f sufficient time (often two or more hours) has elapsed since the arrival of the traveller's flight and

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[298] Mr. Kooner told me that Mr. Dziekanski's mother could have contacted the airline to determine whether her son had arrived. However, Mr. Ehrenholz, the Vancouver Airport Authority's vice-president of Operations told me that the Airport and the airlines are also bound by the *Privacy Act*, and believe that they are prohibited from releasing information respecting whether a passenger has arrived on a flight: Transcript, May 7, 2009, p. 20.

[299] Exhibit 130.

there are extenuating circumstances such as those noted above, the [Border Services officer] may contact a superintendent to assist in locating the traveller."

- Section 3 states that if "sufficient time has elapsed since the flight arrival but no extenuating circumstances exist, the [Border Services officer] may still contact a superintendent" and make inquiries regarding "traffic volumes and processing times."
- Section 4 relates to recently arrived flights, and encourages Border Services officers to tell inquiring greeters that they can check for messages from arriving travellers on a message board in the International Arrivals area.

The standard operating procedure concludes with the statement that Border Services officers "are encouraged to exercise discretion and common sense when the circumstances warrant further approaches (e.g., emergencies and exigent circumstances)." However, definitions or examples of "emergencies" and "exigent circumstances" are not provided.

It is my understanding that CBSA's new standard operating procedure was implemented, at least in part, as a response to perceived inadequacies arising out of the Dziekanski incident. That being so, there are several aspects of the new policy that warrant comment:

- ***Tracking the passenger's progress*** – it does not require that the officer do what, in my view, would be an obvious first step – ascertain whether the passenger has crossed the Primary Inspection Line. I accept that the *Customs Act* and the *Privacy Act* may impose limitations on what information a Border Services officer may convey to a greeter, but determining whether the passenger has reached the Customs Hall is an essential first step in deciding how to respond to a greeter's enquiry. For example, if the officer determines that the passenger has crossed the Primary Inspection Line, then the officer would certainly not suggest that the greeter go home. Depending on the time since the passenger's flight arrival, it might be appropriate to conduct a search of the Customs Hall area.
- ***Status of a sponsor*** – in the case of an arriving immigrant, the new policy gives no recognition to the special status of that passenger's sponsor. It does not require a Border Services officer to ask the relationship between the greeter and the passenger, and it does not give any preferential treatment to the sponsor of a new immigrant.

Sponsors have a highly significant legal role in the immigration process – by becoming the sponsor of a new immigrant, he or she has accepted legal responsibility for the new immigrant's financial well-being. This role should entitle the sponsor to special consideration when making an enquiry about an arriving immigrant. If CBSA is concerned about obtaining the new immigrant's consent for releasing the information that the individual has arrived, I see no reason why this consent cannot be obtained as a matter of course during the immigration process. Mr. Hilton told me that most of the processing for a new immigrant's landing is done overseas. It seems that adding this one additional step – obtaining the new immigrant's consent to tell a waiting sponsor when he or she arrives – could further simplify and improve the new immigrant's experience landing in Canada.

- ***Paging*** – the new policy does not require that the officer page the arriving passenger to receive a message. Mr. Hilton told me that he was not aware of any security concerns in doing so. In addition, Mr. Kooner told me that Border Services officers have access to paging facilities in the Customs Hall, and that there have been no changes to the paging system since the incident.
- ***Extenuating circumstances*** – the new policy focuses on "extenuating circumstances," but does not define that term. If it is meant to refer to the elderly or those with a medical requirement or physical disability it would not extend to people like Mr. Dziekanski – a confused, first-time international traveller who spoke neither of Canada's official languages.
- ***Passive*** – the new policy is drafted passively (e.g., the officer *may* contact a superintendent), rather than imposing a mandatory duty to do so.
- ***Confusing*** – Section 3 is confusing when read in conjunction with Section 2, because it appears to suggest that where there are no extenuating circumstances, a Border Services officer may only make specific types of enquiries. Some Border Services officers might interpret this to mean that they should not attempt to locate a passenger unless certain extenuating circumstances are present.

Conclusions and recommendations

If CBSA implements the single integrated database system I recommended earlier in this part, it should reduce the incidence of arriving international passengers getting "lost" or spending an inordinate amount of time in the Customs Hall. In addition, the Vancouver Airport Authority's new Customs Hall Rover position should assist in identifying and helping passengers who appear lost or confused.

Nevertheless, there will still be greeters who contact CBSA for assistance in finding and getting word to arriving passengers. While CBSA's new standard operating procedure is an improvement, more can and should be done to assist enquiring greeters.

Recommendation 2

I recommend that the Attorney General urge the appropriate federal minister or ministers:

- To implement a policy of inviting each prospective immigrant, when applying overseas for immigrant status, to consent in advance to their sponsor being informed when they do enter Canada.
- To impose a duty on a Border Services officer at the Vancouver International Airport, who receives an enquiry from a greeter about an arriving international passenger:
  - To determine whether the passenger has crossed the Primary Inspection Line.
  - If the passenger has crossed the Primary Inspection Line more than two hours ago, to page the passenger and to record in the passenger's file in the proposed single database system the particulars of the greeter, the greeter's relationship to the passenger, any special assistance that the passenger may require and, where appropriate, a message from the greeter to the passenger; and
  - If the passenger has not crossed the Primary Inspection Line, to make a note in the proposed single database system containing similar information.
- To impose a duty on a Border Services officer at the Vancouver International Airport, who deals with an arriving international passenger at Secondary Customs or Secondary Immigration, to inform the passenger:
  - of the details of any enquiry by a greeter that is recorded in the proposed single database system; and
  - how the passenger may communicate with the greeter.
- To install in the Customs Hall one or more closed-circuit TV monitors showing the greeters who are waiting in the public Meeting

> Area of the International Terminal Building, unless the minister is satisfied that there are legitimate security reasons for not doing so.

6. Interpretation services

a. Introduction

As discussed earlier in this report, Mr. Dziekanski had access to printed materials in Polish when he completed the Customs Declaration Card prior to approaching the Primary Inspection Line. Thereafter, when dealing with CBSA officials at the Primary Inspection Line, at Secondary Customs, at Secondary Immigration, and at the Point, he had no access to a Polish interpreter or to printed materials in Polish. Communication was limited to showing officials his papers, to hand signals and gestures, and, in the case of Border Services Officer Chapin, to a rudimentary knowledge of a few Polish words.

I was interested to learn whether the treatment Mr. Dziekanski received was typical of arriving international passengers who speak neither of Canada's official languages and, if so, whether any significant changes have been introduced since his death.

b. The national picture

Mr. Hilton told me that Border Services officers interact, on a daily basis, with passengers who do not speak English or French. However, it is not mandatory for officers to use an interpreter while processing such a passenger, unless there is a question of that person's inadmissibility to enter Canada, such as a possible deportation. Outside of these circumstances, Border Services officers are trained to use "coping mechanisms" to deal with a language barrier.

CBSA allows its officers to process travellers at Secondary Customs based on inspection alone, and at Secondary Immigration based on documentation alone. In particular, there is no requirement for an officer to call for an interpreter while processing a new permanent resident, because admissibility issues have already been dealt with overseas.

Having said that, CBSA does not prohibit Border Services officers from calling an interpreter. If a passenger appears to be experiencing difficulty due to a language barrier, an officer may attempt to call an interpreter, but will avoid delaying the traveller needlessly. There has been no change to CBSA's national policies regarding interpreters since October 2007.

Mr. Hilton did not have detailed knowledge concerning the interpretation resources available at specific airports. He did tell me that at most ports of entry, CBSA keeps a multilingual leaflet to assist passengers who do not speak English or French with filling out the Customs Declaration Card. Mr. Dziekanski used this leaflet in completing his card.

c. *The situation at the Vancouver International Airport*

Mr. Kooner told me that officers at Vancouver International Airport have several options for contacting an interpreter. The following services were available in 2007, as they are today:

- CBSA employs interpreters on site for several languages.
- CBSA maintains a list of staff members who speak different languages and can be contacted to assist.
- Officers can access a database of interpreters, who can be contacted individually by telephone.
- Officers have access to a 24-hour interpreter phone line.
- Officers are allowed to access any interpretation services provided by the Airport, and may also request assistance from airline personnel.

Notwithstanding this impressive list of options, the Border Services officers who dealt with Mr. Dziekanski did not call an interpreter to assist, for various reasons. For example, when Officer Van Agteren accessed the interpreter database, she discovered that all of the Polish interpreters were either unavailable or did not wish to be contacted for an interview of less than two hours. Officer Purewal, an officer at Secondary Immigration, testified that she did not know of a phone that had interpreter access. Supervisory Officer Currie, also at Secondary Immigration, was unaware of the

24-hour interpreter phone line and did not know about CBSA's list of staff members who speak other languages.

I also heard evidence that interpretation is not routinely provided in circumstances where the arriving passenger has a need to understand what the officer is communicating. For example:

- Officer Kullar told me that an officer at the Primary Inspection Line who is unable to communicate with a non-resident must refer that passenger to both Secondary Customs and Secondary Immigration. But there appears to be no system in place to ensure that the passenger understands where he or she must go, why, or how to get there.
- When a foreign-language-speaking passenger reaches a secondary location, it is unusual for an interpreter to be used. Officer Bharya told me that an interpreter is not usually called at Secondary Customs if informal sign language appears effective. Officer Purewal testified that calling an interpreter to Secondary Immigration to assist by telephone occurs very infrequently.
- Officer Chapin described his interaction with Mr. Dziekanski at Secondary Immigration. He had a duty to obtain answers from Mr. Dziekanski to three specific questions before he could be processed as a landed immigrant: (1) Are you married? (2) Do you have any children? (3) Have you ever been arrested? Rather than resorting to an interpreter, Mr. Chapin relied on his rudimentary understanding of a few Polish words to get the answers he needed. He pointed to his ring finger and said, "My love" in Polish to ask Mr. Dziekanski if he was married. He made a gesture for holding a small baby and said, "Little family" in Polish to ask if Mr. Dziekanski had children. He said, "Police problem?" in Polish to ask if Mr. Dziekanski had been charged with any criminal offences before his arrival in Canada. I commend Mr. Chapin for using his best efforts to communicate with Mr. Dziekanski, but this scenario, when viewed dispassionately, borders on the farcical. It is not enough to answer that landed immigrants are considered "low risk" because the majority of processing has been done overseas. If CBSA officers are required to get proper answers to these questions before admitting a landed immigrant to Canada, surely CBSA has a duty to ensure that officers have ready access to the tools they need in order to get accurate and reliable information from passengers. This would not necessarily require the services of an interpreter. CBSA officers in Secondary Immigration could be provided with printed forms in numerous languages (similar to the multilingual guides used for completion of the Customs Declaration Card) that pose the three

> mandatory questions, with "Yes" and "No" boxes for the immigrant to complete.

CBSA's *People Processing Manual* has a chapter on "Awareness Issues" and a list of guidelines and procedures related to language issues under the heading "Effective Cross-Cultural Communication." One procedure states that travellers who do not speak English or French should be referred to secondary areas "for the services of an interpreter."[300] This procedure goes to the heart of showing cultural sensitivity to a newly arrived person, by ensuring that the individual can receive assistance that he or she can understand.

d. Recent changes

CBSA has implemented two changes at the Vancouver International Airport since October 2007. First, it has updated its list of interpreters by removing people who are no longer available and by adding new people to the list. Second, the list of CBSA staff who can speak other languages has also been updated.

Conclusions and recommendations

Several realities emerge from this review. First, many of the CBSA officers who dealt with Mr. Dziekanski appeared to be unaware of some of the interpretation services that were apparently available to assist them when dealing with travellers who speak neither of Canada's official languages. Nothing I heard suggests that this has changed.

Second, there appears to be a disconnect between the laudable language of the *People Processing Manual* and the day-to-day practice. The manual promotes the use of interpreters, but according to Mr. Hilton, officers are trained to use "coping mechanisms" to deal with language barriers.

Third, this disconnect may result from a well-intentioned desire to move a massive number of arriving international passengers through the Customs Hall as efficiently as possible. It appears to have led to a mindset among CBSA officers of getting by without resort to interpreters whenever possible. But this goal of efficiency comes at a cost:

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[300] Exhibit 121, Section 14, p. 4.

- People like Mr. Dziekanski have no way of communicating effectively with the officers, do not understand what is required of them, do not know where to go or why, and are largely left to their own devices. It is a singularly unimpressive way to welcome foreigners to our country, especially new immigrants.
- CBSA officers' resorting to "coping mechanisms" (such as Mr. Chapin's well-intentioned exchange with Mr. Dziekanski) means that CBSA is not getting accurate and reliable information from arriving passengers on presumably important matters.

At a more elementary human level, greater use of interpretation services for arriving international passengers could make an enormous difference to their experience. In Mr. Dziekanski's case, for example, giving him a printed form in Polish when he crossed the Primary Inspection Line, telling him that he had to go to Secondary Customs and then Secondary Immigration, and how to get to each, may well have prevented his five-and-a-quarter-hour disappearance in the Customs Hall. When he eventually reached Secondary Immigration in a distressed state, a Polish interpreter could have explained to him the processing of his immigration papers, asked him why he had been in the Customs Hall so long, advised him that his mother had been at the Airport and had called looking for him, and that she might have driven home to Kamloops, but that they were calling her at home to let her know that he was still there. The interpreter could have given him some advice about where he could go in the Airport in the middle of the night until she came back. We know how Mr. Dziekanski was treated, but we do not know how many others have experienced similarly unsatisfactory service.

Recommendation 3

I recommend that the Attorney General urge the federal Minister of Public Safety to ensure that:

- CBSA officers at the Vancouver International Airport receive training, regularly updated, on what interpreter services are available to them and to arriving international passengers, and how to access such services.

- CBSA provide its officers at the Vancouver International Airport with adequate resources (e.g., interpreter services, printed multilingual forms, etc.) to ensure that arriving international passengers:
  - know where they have to go within the Customs Hall, and how to get there;
  - know what is being asked of them, when an officer is required to seek specific information, and are able to communicate such information to the officer;
  - know if a greeter has attempted to contact them; and
  - are assisted in their own language, if they appear to be confused or distressed.

C. VANCOUVER AIRPORT AUTHORITY

1. Introduction

Vancouver International Airport is operated by the Vancouver Airport Authority, a non-profit corporation that reports to a broadly based board of directors. Board members are appointed by nominating entities, including the City of Richmond, the City of Vancouver, Metro Vancouver, the Government of Canada, the Vancouver Board of Trade, and three professional governing bodies.

During daytime hours, the Airport has 60-65 flight arrivals and departures each hour. On an average day, 12,000 passengers go through the International Arrivals process. At peak times, that volume may reach 1,500-2,000 passengers each hour.

2. Policy witness

The Vancouver Airport Authority tendered **Don Ehrenholz**, currently vice-president of Operations, to testify respecting Airport policies and procedures, and to describe the Airport Authority's comprehensive review undertaken following Mr. Dziekanski's death. In addition, the Airport Authority also provided extensive documentary materials dealing with training, policies, and emergency procedures, as well as several reports prepared for the Airport Authority by outside consultants.

Earlier in this report I made reference to the testimony of numerous Airport Authority employees or contractors, many of who had some interaction with Mr. Dziekanski on October 13 or 14, 2007. I will refer to some of these witnesses' testimony in this part, but on matters of Airport Authority policy, I will rely on the testimony of Mr. Ehrenholz and the materials tendered through him.

3. The Airport Authority's internal review following Mr. Dziekanski's death

Mr. Ehrenholz told me that, prior to October 2007, the Vancouver Airport Authority had never seen a situation similar to the one involving Mr. Dziekanski. In order to ensure that such a situation would never occur again, the Airport Authority appointed Mr. Ehrenholz in November 2007 to lead an internal task force. His mandate was to undertake a review process of the Airport's procedures, make recommendations for change, and implement the recommendations after approval from the board of directors.

Mr. Ehrenholz and the internal task force spent six weeks reviewing every aspect of Mr. Dziekanski's and his greeters' experiences at the Airport, to ascertain what happened and to identify areas where changes could be recommended. They also conducted town hall meetings to provide an opportunity for employees to suggest changes for improving the Airport, and they consulted with various external agencies including the City of Richmond, the Canada Border Services Agency, the Canadian Air Transport Security Administration, the United States Customs and Border Protection, and several other agencies that operate at the Airport.

The ultimate goal of Mr. Ehrenholz's internal task force was to review and change the Airport's systems so that they would "deal with the needs of every customer, no matter what the time of day, no matter whether they are in the areas controlled by the [Vancouver Airport] Authority, the Customs Hall controlled by the federal government, or in spaces occupied by the airlines."[301]

On December 7, 2007, the Vancouver Airport Authority announced 33 changes that were planned for the Airport. Some of these changes had already come into effect, while others were scheduled for future implementation.[302] At the time Mr. Ehrenholz testified in May 2009, all 33 changes had been fully implemented.

Mr. Ehrenholz also told me that the Vancouver Airport Authority retained an external consultant, InterVISTAS, to review its customer service processes with a view to comparing Vancouver International Airport to other airports, both domestic and international. In particular, the Airport Authority wanted to determine if the Airport was lacking in certain customer care areas, and to obtain information regarding best practices at other airports. In InterVISTAS' first report, released in January 2008, Vancouver International Airport was ranked as having best practices in some categories, while other airports received higher rankings in some other categories. After Mr. Ehrenholz's internal task force had implemented a significant number of changes, InterVISTAS conducted a second review to audit those changes. This update report, released on March 13, 2009, verified the changes, and reported that Vancouver International Airport now had the best practices in several additional areas.

I do not propose to review, in detail, the 33 changes implemented by the Airport Authority, or the findings of the two InterVISTAS reports. Rather, I will focus on the following four general areas, to assess the adequacy of the Airport Authority's response to the Dziekanski incident:

- customer care for passengers and greeters;
- communication between arriving passengers and greeters;
- safety and security; and
- emergency and medical response.

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[301] Transcript, May 7, 2009, p. 5.

[302] Exhibit 126, Tab 2.

4. Customer care for passengers and greeters

Earlier in this report, I documented how Mr. Dziekanski disappeared from view within the Customs Hall for five-and-a-quarter hours how his mother and Mr. Hutchinson repeatedly tried, unsuccessfully, to get word to her son and how no one provided Mr. Dziekanski with access to an interpreter when he was in the International Reception Lounge. I was interested to learn what steps the Vancouver Airport Authority has taken since then to improve customer care services to arriving international passengers and to greeters.

Mr. Ehrenholz told me that there are thousands of people working at the Airport. Only approximately 400 of these are direct employees of the Airport Authority. Many others are directly employed by airlines or government agencies, and still others are employees of private firms such as Marquise and Securiguard, which contract with the Airport Authority to provide customer service and security services respectively. For example, in October 2007, Marquise employees included the visitor/information counsellor at the BC Visitor Centre, the customer service agent at the Customer Information booth in the Departures area, and the customer service agents in the pre-Primary Inspection Line area of the Customs Hall.

Mr. Ehrenholz told me about the improvements to customer care that the Airport Authority has introduced, which I will summarize.

a. New training program

One of the Airport Authority's early changes was to create a comprehensive new training program, with the intent to encourage everyone who works at the Airport to be more proactive in seeking out people who need assistance. The training also teaches that if an employee is unable to assist a passenger, he or she should take that passenger to an Airport customer service agent to receive the assistance that passenger needs.

Nearly all Airport Authority employees have received the new training, and in addition, a large percentage of contracted employees, including Marquise, Securiguard, and the baggage cart retrievers, have been trained. The Airport has also run a course for Canada Border Services Agency officers. When Mr. Ehrenholz testified in May 2009, the Airport Authority was also running courses for U.S. Customs agents. It was developing courses for employees of the Canadian Air Transport Security Administration and online courses to train airline customer service agents.

b. Customer care cards

The Airport Authority discovered that employees would begin to forget, within three to six months, basic information they had been taught during the new training program. To address this issue, the Airport Authority is now providing Customer Care Cards to approximately 70 percent of all people working at the Airport – those who hold a "Restricted Area Identification Card," which gives them airside access.

The Customer Care Card contains key pieces of information reminding employees what to do if a passenger asks for assistance, including how and where to access the Language Line (a phone line that provides translation services for over 170 languages), how to identify Airport customer service personnel, and how and where to access help phones. The Customer Care Card also advises that if the worker is unable to provide the traveller with assistance, the worker should escort the traveller to a Customer Information counter or a help phone. Customer Care Cards are now handed out every time a worker renews their Restricted Area Identification Card – approximately 5,000 have been issued to date, covering all frontline staff in the terminal complex.

c. International Arrivals Response Coordinator

Mr. Ehrenholz and the internal task force realized that a mobile Airport Authority employee would be beneficial to help passengers in some unique circumstances (e.g., Mr. Dziekanski, or his mother), but were aware that customer service agents could not provide this service because they were generally required to stay in place.

Consequently, the Vancouver Airport Authority has negotiated special protocols with the Canada Border Services Agency to allow a newly created International Arrivals Response Coordinator to go in and out of the Customs Hall to deal with certain types of issues, including safety, security, or customer service, or to simply assist arriving international travellers.

d. Customs Hall Rover position

The Airport Authority has also created a new Customs Hall Rover position. This employee is required to perform hourly sweeps throughout the entire Customs Hall, including the escalators, the carousel area, and the bathrooms, to look for people who need assistance, who are lost, or who are having difficulties. The Airport Authority has both a female and a male rover to check in both bathrooms. The rovers are also required to keep records of their sweeps.

The Airport has conducted an audit of its new rover position, using a lost "mystery passenger" in the Customs Hall – the mystery passenger was identified by the rover within an hour. The Airport's rovers have dealt with at least one real-life situation involving a lost person suffering from dementia in the Customs Hall, who was located and given assistance within an hour.

e. Re-designed customer information counter

In October 2007 a BC Visitor Centre separated the area between the International Reception Lounge and the public Meeting Area. It was dedicated to providing tourist information; yet one visitor/tourism information counsellor told me that on an average day approximately half of its 100-200 daily enquiries would be for information about flights, passengers, or Airport services. The Visitor Centre had no resources to handle such enquiries, since the booth's computers did not provide access to baggage or flight information, the booth did not have paging facilities, and personnel at the booth had no one they could call for special assistance.

As part of the overall re-design of the International Reception Lounge and the public Meeting Area, a new Tourism BC Visitor Centre has been built – one continuous counter with direct access from both the public Meeting Area and the International Reception Lounge. Customer care personnel in this area can now dispense flight information and assist customers in any way possible. It is staffed 24 hours a day, seven days a week.

f. Improved resources for customer service agents

The Airport Authority has provided all customer service agents with mobile communication devices (BlackBerries), which they can use to call for emergency assistance, call the Operations Centre, or access the Language Line. The Airport Authority has added dual-handset telephones to all Customer Information areas, which can be used with the Language Line to access interpreters for over 170 different languages, 24 hours a day.[303] The dual handset allows one person to speak a language and the other person to hear an interpreter's translation of what has been said, and then reply.

In addition, the Airport Authority has distributed language identification cards to customer service agents. These cards contain the following statement in the 20 most commonly used languages: "Point to your language. An interpreter will be called. The interpreter is provided at no cost to you."[304] The Airport has also placed globes at all customer service information booths, so that passengers who speak a language not listed on the cards can identify other languages by pointing to their country of origin.

g. New customer information counters in Customs Hall

In addition to the Customer Information counter near Secondary Immigration, the Airport Authority has installed two new Customer Information counters in the Customs Hall – the one near the baggage carousels is open whenever the Customs Hall is open, and the one in the pre-Primary Inspection Line is open between 8 a.m. and 8 p.m. They are staffed by customer service agents well versed in issues important to arriving international passengers. These counters have the same resources as other customer

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303 As part of the Airport's monitoring program of its new initiatives, employees at Customer Information Counters record each usage of the Language Line. On average, the Language Line is used 150 to 200 times per month.

304 Exhibit 167B, Tab 12.

information counters, including dual-handset telephones to contact interpreters using the Language Line, language identification cards, and globes.

h. Help phones

The Airport Authority has placed help phones along every second post inside the Customs Hall, with larger and brighter pictogram signage. Help phones can be used to access Airport Operations, call the police for a non-emergency event, or call 911 for an emergency. If the passenger calls Airport Operations, they can access assistance or be connected to the Language Line for interpretation services. If a passenger does not dial, perhaps because they do not understand how the help phone works, that passenger will automatically be connected to Airport Operations within three seconds.

i. New "Paddle Initiative"

There is a "Voluntary Compliance Corridor" located in the Customs Hall, which allows new immigrants to bypass the Primary Inspection Line and go directly to Secondary Immigration. The "Paddle Initiative" involves a paddle-shaped sign located in the pre-Primary Inspection Line area that reads "New Immigrants, New Students, New Workers" in English and two other languages, with a large arrow directing travellers toward the Voluntary Compliance Corridor. Customer service agents in the area are trained to notice if a passenger is carrying immigration documents and to ask questions to determine if a passenger is a new immigrant and, if so, to direct the individual to the Voluntary Compliance Corridor. The Airport Authority's audit of the Paddle Initiative showed that a large number of people appear to be using the system. This saves new immigrants time and allows them to leave the Customs Hall sooner.

j. Improved wayfinding measures

The Airport Authority has improved signage in the Customs Hall, adding LCD screens to assist travellers in finding their own way to the public Meeting Area. These screens cycle through French and English, and the four other most commonly used languages at the Airport – Spanish, Korean, Mandarin, and Punjabi.

Mr. Ehrenholz told me about other subtle wayfinding measures, such as adding a pattern of lights, and designs to the carpet, to guide passengers to find their way out, and improved tear-off maps of the Customs Hall and the Airport, which customer service agents can give to travellers to show them where to go.

Conclusions

I am impressed with the Airport Authority's prompt and thorough review of its customer care services that it undertook following Mr. Dziekanski's death, and the extensive changes that it has implemented. I am satisfied that if these services had been in place in October 2007, Mr. Dziekanski would not have gone missing for five-and-a-quarter hours, would have had prompt access to an interpreter and, in all likelihood, would have been reunited with his mother. I have no other changes to recommend.

5. Communication between arriving passengers and greeters

Earlier in this part, I discussed the *Customs Act* and the *Privacy Act*. According to CBSA, these statutes preclude disclosure of information about arriving international passengers to greeters. Mr. Dziekanski's mother was repeatedly frustrated in trying to get information about him or in trying to get a message to him. I will now examine the same issue from the perspective of the Vancouver Airport Authority and review what steps it has taken since October 2007 to improve communication between passengers and greeters.

a. Telephone communication between passengers and greeters

It has always been possible for a greeter in the public Meeting Area and a passenger in the Customs Hall to communicate with each other, either by pay phone or cell phone. The Airport Authority has made several recent changes to assist passengers and greeters who do not have cell phones:

- The Airport Authority's customer service agents will now provide coins to allow arriving international passengers to place a call from a pay phone in the Customs Hall.
- Customer.service agents are trained to allow passengers to use the agents' BlackBerries, to place outgoing calls.
- A customer service agent who is dealing with a greeter in the public Meeting Area could phone through to a customer service agent in the Customs Hall who is dealing with the passenger that the greeter is waiting for.

b. Greeter information board

Mr. Ehrenholz told me that the Airport Authority worked closely with CBSA to implement the new "Greeter Information Board" system. Arriving international passengers may ask an Airport customer service agent in the Customs Hall to put his or her name, departure point, and time of arrival onto an electronic board that is displayed in the public Meeting Area. This allows greeters to see that the passenger has arrived and is present in the Customs Hall. The passenger's information remains on the Greeter Information Board for two hours. According to Mr. Ehrenholz, the principal users of this system are passengers in the Secondary Immigration area. CBSA allows Airport customer service agents to enter this area and ask the people waiting if they would like to have their name placed on the Greeter Information Board. The Greeter Information Board is a notable improvement (for passengers who know about it), but it is a "one way" service – there is no comparable board in the Customs Hall on which greeters can post a message.

c. CBSA storefront counter

The Airport Authority has worked with CBSA to create a "storefront" location in the public Meeting Area. This allows an awaiting greeter to speak to a Border Services officer and to make enquiries, when a customer service agent cannot provide information regarding a passenger in the Customs Hall. While I commend the Airport Authority and CBSA for taking this initiative, it may have limited usefulness as long as officers are prohibited from releasing information about travellers without the travellers' consent.

d. Paging

CBSA officers can page arriving international passengers in the Customs Hall and in the public Meeting Area, and customer service agents working in the Customs Hall for the Airport Authority and for the airlines can page passengers within the Customs Hall. However, the Airport Authority's customer service agents are not permitted to page from the public Meeting Area into the Customs Hall, or *vice versa*. While Mr. Ehrenholz told me that CBSA is concerned that such paging would violate border security laws, the CBSA's senior policy advisor told me that he did not know of any security concerns relating to paging.

e. Passenger record of entry and exit

According to Mr. Ehrenholz, the Airport Authority has been unsuccessful in obtaining CBSA's agreement to implement a new "Passenger Record of Entry and Exit" system. This system would collect and time-stamp passengers' passport data at the Primary Inspection Line, and then track passengers as they progress through the Customs Hall, including passengers who are referred to Secondary Customs and/or Secondary Immigration. When greeters provide detailed information regarding the passenger (e.g., birth date), Airport Authority staff at Customer Information counters would query a passenger's status in the Customs Hall, and pass this information on to the greeter.

According to Mr. Ehrenholz, the Airport Authority is not allowed to implement the system because it involves "customs information," which only Border Services officers are permitted to handle. He testified that the Airport Authority supports CBSA implementing the system because it would provide a method to track a passenger who spends a prolonged period of time in the Customs Hall. He indicated that CBSA is looking at this system.

Conclusions and recommendations

I acknowledge the efforts made by the Vancouver Airport Authority and CBSA, separately and collectively, to improve communication between arriving international passengers and greeters. However, more can and should be done.

I unreservedly endorse the Airport Authority's attempt to introduce a Passenger Record of Entry and Exit system. It is probably the single most significant reform that CBSA could introduce to monitor arriving international passengers, track their progress through the Customs Hall, and alert CBSA officers when there are unexplained delays in a passenger's progress.

Earlier in this part, I recommended that the Attorney General urge the federal Minister of Public Safety to implement a single integrated database system for precisely this purpose. I remain hopeful that this recommendation will be acted on.

With respect to communication between arriving international passengers and greeters, I do not understand CBSA's lack of action on several issues:

- mounting a Passenger Information Board in the Customs Hall, on which waiting greeters could place their name, so that arriving passengers were aware of their presence; and
- not allowing the Airport Authority's customer service agents to page from the public Meeting Area into the Customs Hall, and *vice versa.*

In neither case is CBSA being asked to disclose confidential passenger information, nor am I aware of any other security concerns. If greeters and passengers can communicate directly with each other via cell phones, there seems to be no reason why these types of services cannot be provided so passengers and greeters can communicate indirectly.

Recommendation 4

I recommend that the Attorney General urge the federal Minister of Public Safety:

- To install, in the Vancouver International Airport's Customs Hall, a digital Passenger Information Board on which waiting greeters can place their name, so that arriving passengers are aware of their presence.

- To permit the Vancouver Airport Authority's customer service agents to page from the public Meeting Area into the Customs Hall, and *vice versa*.

6. Safety and security

The Vancouver Airport Authority contracts with Securiguard for safety and security services at the Airport. At any given time, 20-30 Securiguard personnel act as:

- security patrollers, moving throughout the Airport to respond to disturbances or medical distress calls; or
- access control point guards, stationed at certain doors to protect the Primary Security Line that separates public areas of the Airport from secure areas.

Security patrollers are prohibited by provincial law from carrying any kind of weapon, defensive tool, or restraining device. They are bound by an "observe and report" policy, which specifically prohibits them from engaging in physical force, even in cases of property damage or violence, except when they need to protect themselves. In violent situations, security patrollers are taught to report back to the Security Operations Centre or to the security shift manager. The RCMP will be called in cases involving violence to people or property, incidents of theft and vagrancy, or suspicious circumstances.

During the Dziekanski incident, three security patrollers, who were together on a tea break in the Domestic Terminal, attended the International Reception Lounge. It took them approximately seven minutes to reach the lounge. One of the security patrollers asked questions of several witnesses and persuaded Mr. Dziekanski to put down a computer and to calm down. They realized that Mr. Dziekanski did not speak English, but did not alert the Security Operations Centre of that fact and took no steps to obtain interpreter assistance. Otherwise, they adhered to their "observe and report" mandate until the RCMP officers arrived several minutes later.

I was interested to learn of four changes that the Airport Authority has made to its safety and security services since October 2007:

- It has installed two additional closed-circuit cameras to view the International Reception Lounge;
- It has extended training about the Language Line to all security personnel;
- It has provided training in de-escalation techniques to all 80 frontline Operations personnel; and
- It has created a new Public Safety Officer position. These Securiguard officers are trained in verbal de-escalation techniques. One of these public safety officers is on duty at all times.

Conclusions and recommendations

Vancouverites are justifiably proud of their international Airport. The Airport Authority's thousands of direct employees and employees of contractors serve tens of thousands of travellers who arrive and depart daily, as well as the many thousands of friends and family members who meet or bid farewell to travellers.

With such a busy enterprise, it is inevitable that there will be medical and behavioural crises, and often it will be the security patrollers employed by Securiguard who are the first responders. It surprised me to learn that these patrollers have no mandate to intervene in emergency situations. My understanding is that they are not expected to provide first aid or to use verbal de-escalation techniques, and are bound only to "observe and report." Such a mandate may be appropriate for security patrollers in a small suburban mall, but in my view more should be expected of first responder security patrollers at such a large, busy, and prestigious international Airport.

I am not suggesting that the security patrollers carry weapons or restraining devices or physically intervene in violent situations, but I do think that the current "observe and report" mandate is inadequate. The travelling public would be much better served if security patrollers received training in first aid and verbal de-escalation techniques, and were expected to actively assist members of the public who are in distress.

Recommendation 5

I recommend that the Vancouver Airport Authority:

- Revoke the current "observe and report" mandate applicable to its contracted security patrollers.
- Set minimum standards for security patrollers that include:
  - training in first aid (including CPR) and verbal de-escalation techniques; and
  - an expectation that they will actively assist members of the public who are in distress.

7. Emergency and medical response

In addition to its Operations personnel and the contracted-out safety and security services described above, the Vancouver Airport Authority has its own in-house capacity to respond to aircraft and medical emergencies. Emergency Response Services operates on a 24-hour, seven-day-a-week basis. Its members are trained to firefighter standards, although their training focuses on air crash rescue, not structural fires. They are also trained to be first responders to medical emergencies.

In other respects, the Airport Authority relies on external emergency services, such as the RCMP and Richmond Fire-Rescue (accessed via E-Comm dispatch services), and the BC Ambulance Service.

In October 2007, the BC Ambulance Service stationed bicycle-equipped paramedics on site in the Airport terminal between 6:30 a.m. and 5:30 p.m. Outside these hours, the BC Ambulance Service was dispatched from Richmond, and the Airport's Emergency Response Services personnel responded to Code 3 medical emergencies.

Earlier in this report, I summarized what happened during the Dziekanski incident – Cst. Bentley requested that his call for an ambulance be upgraded to Code 3 and the BC Ambulance Service dispatched basic and advanced life support units, but the Airport Authority's airport response coordinator directed that Emergency Response Services not be dispatched, and one of the Airport's automated external defibrillators was not brought to the scene. An RCMP officer refused the firefighters' request to remove the handcuffs, but subsequently complied with a paramedic's request.

I was interested to learn what changes have been implemented since the Dziekanski incident, particularly to deal with cases where a police use-of-force incident evolves into a medical emergency. Mr. Ehrenholz testified about the changes, which I summarize as follows:

- During the period when the BC Ambulance Service's "bike squad" is not onsite (between 5:30 p.m. and 6:30 a.m.), the Airport Authority's Emergency Response Services now responds to *all* medical calls (i.e., routine and Code 3).
- Two Emergency Response Services personnel are stationed in the terminal, rather than in ERS's fire hall adjacent to the runways, to facilitate faster response times.
- All 38 Emergency Response Services personnel, previously trained to a First Responder Level 3, are now trained to an Emergency Medical Responder-1, which includes the authority to administer some drugs.

Conclusions and recommendations

I commend the Airport Authority for implementing these changes. Enhancing the medical training of Emergency Response Services personnel is a welcome improvement. So, too, are the decisions to station them in the terminal and to mandate that they respond to *all* medical calls when the BC Ambulance paramedics are not on site. In many instances this is bound to shorten the response time, when a minute or two can make a huge difference.

However, there is one other medical emergency issue that warrants the Airport Authority's attention. The Dziekanski case is an example of a safety and security incident evolving into a police use-of-force incident and then evolving further into a medical emergency incident. The testimony from our evidentiary hearings reveals confusion about who is responsible for what in such situations. There is no question that when the four RCMP officers arrived on the scene they took charge of the incident, and in those circumstances, it was entirely appropriate for the Airport Authority's Operations personnel to defer to them. However, the police use-of-force incident very quickly shifted into a medical emergency incident. In such circumstances, it is not clear whether Operations personnel have an ongoing obligation under Airport Authority policy to monitor the incident and ensure a timely response and, if so, what specific role they should play. Should the RCMP retain operational authority until the medical emergency is resolved, or should Operations personnel play some role, and if so, what role?[305] In what circumstances, if any, should an RCMP officer comply with a medically based request to remove handcuffs?

In my view, the travelling public would be well-served if the Vancouver Airport Authority, the RCMP, Richmond Fire-Rescue, and the BC Ambulance Service worked together in formulating a plan of action for dealing with police use-of-force incidents that evolve into medical emergencies, the goal being to ensure that the subject receives appropriate medical care and/or treatment as promptly as possible, compatible with public safety.

Recommendation 6

I recommend that the Vancouver Airport Authority, RCMP, Richmond Fire-Rescue, and BC Ambulance Service:

- Work together in formulating a plan of action for dealing with police use-of-force incidents at the Vancouver International Airport that evolve into medical emergencies.
- Train, with regular updates, their personnel on any such plan of action formulated by them, including live training exercises.

D. CONCLUDING COMMENTS

The Vancouver Airport Authority has taken exceptional steps in the aftermath of Mr. Dziekanski's death to identify inadequacies in its policies, practices, and procedures, and to remedy them. I commend the Authority and its employees for their prompt, thoughtful, and comprehensive response.

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[305] The Airport Authority already conducts training exercises (e.g., aircraft accident, terrorism/security incident) involving all relevant community agencies, to ensure that everyone knows their role and that there is a coordinated response.

Regrettably, I cannot be as complimentary of the response of the Canada Border Services Agency. I am not aware of any comparable comprehensive review following Mr. Dziekanski's death, and any changes to its policies, practices, and procedures are minor and few. For example, I would have expected CBSA to have moved promptly to implement changes to ensure that no future arriving international passenger gets "lost" in its Customs Hall for five-and-a-quarter hours. Based on the evidence led at our evidentiary hearings, CBSA has taken no steps to do so, leaving it up to the Vancouver Airport Authority's new Customs Hall rovers to make hourly sweeps of the CBSA's Customs Hall to look for people who need assistance, who are lost, or who are having difficulties. In addition, CBSA appears to oppose several other reforms, apparently for reasons not grounded in security or traveller confidentiality:

- installation of a Passenger Information Board in the Customs Hall area, so that an arriving passenger can learn of a greeter waiting for them in the public Meeting Area;
- paging from the public Meeting Area into the Customs Hall, and *vice versa*; and
- electronically recording each arriving international passenger's arrival at the Primary Inspection Line and tracking their progress through the Customs Hall, and issuing alerts when a passenger's progress is too slow.

I am satisfied that the changes already implemented by the Vancouver Airport Authority, if supplemented by the recommendations I have made above, will dramatically improve the experience of arriving international passengers, especially those such as Mr. Dziekanski who speak neither of Canada's official languages, are inexperienced travellers, and are, for any number of reasons, fatigued, confused, or distraught. For example:

- Customer service agents in the pre-Primary Inspection Line area can now offer greater assistance to foreign-language-speaking travellers, by connecting them to an interpreter through the Language Line;
- Such agents can also steer immigrants through the Voluntary Compliance Corridor, thereby enabling them to go directly to Secondary Immigration and avoid the Primary Inspection Line;

- Foreign-language-speaking travellers at the Primary Inspection Line would be told, in a manner that they understand, where else they have to go and how to get there;
- Customer service agents in the Secondary Immigration area can suggest to travellers that they place their name on the Greeter Information Board so that waiting greeters will know of their arrival in Vancouver. The agents can also give travellers coins for a telephone or let them use their BlackBerry to make a local call, and can access an interpreter through the Language Line;
- The Airport Authority's Customs Hall rovers move throughout the Customs Hall area, looking for people who need assistance, who are lost, or who are having difficulties;
- Implementation of my proposed integrated database system would track the progress of each arriving international passenger as they move through the Customs Hall and issue an alert when a passenger does not reach the next location within a predetermined time, prompting a search for the passenger;
- A waiting greeter can get assistance from the CBSA's storefront counter and can obtain assistance from the Airport Authority's International Arrivals response coordinator. If my recommendations are adopted, the greeter could have the passenger paged or could post their name on a Passenger Information Board in the Customs Hall, so that the passenger knows that a greeter awaits them;
- Border Services officers at Secondary Immigration would ensure that new immigrants know what is being asked of them, are able to communicate with the officer, and are assisted in their own language;
- A sponsor of an arriving immigrant would be entitled to be informed whether the immigrant has arrived in Vancouver and, if so, to leave a message for them;
- An arriving international passenger who has exited the Customs Hall has 24-hour access to a customer service agent at the Tourism BC Visitor Centre in the public Meeting Area, for assistance; and
- An arriving passenger who is in distress in the International Reception Lounge or public Meeting Area would be assisted by security patrollers, who could access an interpreter through the Language Line, and who could provide first aid and/or use verbal de-escalation techniques to assist a distraught traveller.

Notwithstanding the Vancouver Airport Authority's impressive response to Mr. Dziekanski's untimely death, more still needs to be done, both by the federal authorities and the Airport Authority, and the Canadian public needs some assurance that these additional reforms will be implemented, or if not, why not.

When the provincial Minister of Public Safety and Solicitor General announced the establishment of this Commission of Inquiry in November 2007, he committed the provincial government to action:

> This incident has British Columbians, Canadians and people all over the world seeking answers with regard to not only this human tragedy, but also how the province welcomes the world to our airport. By calling a full public inquiry, we want everyone to know that all the facts will be put on the table, we will take action based on those facts and we will learn from this tragedy.

I am confident that the provincial government will keep this promise.

Recommendation 7

I recommend that, within two years of this report being made public, the provincial Minister of Public Safety and Solicitor General report publicly and in writing to the Legislative Assembly on the extent to which the federal government and the Vancouver Airport Authority have implemented the recommendations contained in this report, and if one or more recommendations have not been implemented, the reasons why.

PART 9: RECENT CHANGES AT VANCOUVER INTERNATIONAL AIRPORT

PART 10

POSTSCRIPT— POLICE INVESTIGATING THEMSELVES

PART 10: POSTSCRIPT – POLICE INVESTIGATING THEMSELVES

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A. INTRODUCTION

In Part 8, I discussed the RCMP's release of inaccurate information to the public about the Dziekanski incident soon after it happened and the decision that was made a few days later not to immediately correct the public record. I concluded that the intense public reaction against the RCMP's handling of its media response arose because the RCMP's Integrated Homicide Investigation Team was conducting the investigation to determine whether any RCMP officers should be charged criminally, and there were suspicions that inaccurate information was released deliberately in order to cast the officers' conduct in a more favourable light.

It was a case of the police investigating themselves, which gives rise to legitimate concerns about conflict of interest. Many members of the public perceive that the investigators may allow loyalty to fellow officers to interfere with the impartial investigative process. This perception, even if not justified in a given case, can lead to public distrust and an undermining of public confidence in the police.

When testifying during our evidentiary hearings, Supt. Rideout, who was at the time of Mr. Dziekanski's death the officer in charge of IHIT, was asked for his opinion about whether the RCMP should have been investigating its own officers in the Dziekanski matter. He stated:

> And I think they were asked to do a very difficult job and [it] was very difficult. You know, we're not good at this. Let's be, let's just cut to the, like, we shouldn't be doing this. My, that's my opinion. I make no bones about it to the management. Time for an SIU in this province. We can't win this one. It's only going to get worse. We cannot market the RCMP and do an independent investigation at the same time, it can't be done.[306]

Supt. Rideout's reference to "SIU" was a reference to Ontario's Special Investigations Unit, an independent, civilian-led investigation agency established in 1989 to investigate police-related deaths and serious injuries. A similar civilian-led investigative body was recently established in Alberta (the Alberta Serious Incident Response Team), and one has been recommended in Manitoba and Nova Scotia.

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[306] Transcript, September 22, 2009, pp. 88-89.

In British Columbia, my former judicial colleague William Davies, Q.C., undertook a detailed review of this issue during the Frank Paul Inquiry, and he recommended that British Columbia establish a civilian-based investigative agency modelled on Ontario's SIU.[307] Because of Mr. Davies' limited mandate, his recommendation extended only to the 12 BC municipalities policed by 11 municipal police departments.

It should be emphasized that what is under consideration here is *criminal investigations* to determine whether a police officer should be charged with a criminal offence that would be prosecuted through the criminal courts. That process is to be contrasted to *professional standards investigations* that, if substantiated, would lead to internal disciplinary measures, such as suspension. Professional standards investigations are overseen by the provincial Office of the Police Complaint Commissioner (for municipal police officers) and by the federal Commission for Public Complaints Against the RCMP (for RCMP officers).

B. RECENT CALLS FOR REFORM

Since Mr. Davies' February 2009 recommendation for a civilian-based investigative body, three significant events have dramatically altered the landscape:

- In August 2009 the Commission for Public Complaints Against the RCMP recommended that the investigation of all police-related deaths should be referred to an external police service or to a provincial criminal investigative body, and that such a procedure also be considered in police-related serious injuries and sexual assaults.
- In September 2009 the British Columbia Association of Chiefs of Police (which includes the RCMP) recommended a new, independent, provincially established unit to investigate deaths or serious injuries involving police officers, which would be led by a civilian, with police

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[307] See the report of the Davies Commission of Inquiry into the Death of Frank Paul, *Alone and Cold*, Part 6, pp. 199-242.

officers seconded from police departments conducting the investigations.

- In February 2010 RCMP Commissioner Elliott announced a new policy applicable to police-related serious injuries and deaths, and other criminal matters that are of a serious or sensitive nature. In these circumstances, the RCMP will refer the investigation to a provincially or federally established regime. Where no such regime has been established, the RCMP will request that an external law enforcement agency or other duly authorized investigative agency conduct the investigation.

It is gratifying indeed that within a year of Mr. Davies' bold call for reform, all of British Columbia's municipal police departments, and the RCMP nationally, have committed themselves to this profoundly important reform. The debate is no longer whether British Columbians should have a civilian-based investigative body, but what it should look like.

C. PROPOSAL FOR A CIVILIAN-BASED INVESTIGATIVE BODY

1. The Davies model

I have carefully reviewed Mr. Davies' recommendations for a civilian-based investigative body, and the reasons for them. I agree with him that British Columbia should establish such an investigative body, and that it ought to be modelled on Ontario's Special Investigations Unit.

Mr. Davies' proposed model is described in his recommendations, which I reproduce below:

> 4. I recommend that British Columbia develop a civilian-based criminal investigation model for the investigation of police-related deaths occurring in the municipalities policed by the 11 municipal police departments.
>
> 5. I recommend that the initial mandate of this organization (which I suggest be named the Independent Investigation Office (IIO)) include a wide variety of factual circumstances including (but not limited to) a death in a police department jail cell, a death resulting from an officer's use of force or a motor vehicle, or a death arising from some other form of police interaction with the deceased.

6. I recommend that the IIO be accountable to the Ministry of Attorney General.
7. I recommend that the IIO be led by a director appointed by Order-in-Council for a fixed term of five or six years.
8. To ensure the IIO's unquestioned authority to act, I recommend that its essential powers be entrenched in legislation, such as:
    - the IIO director and investigators have the status of peace officers,
    - the chief constable of the jurisdiction in which a police-related death occurs must immediately advise the IIO of the incident,
    - pending arrival of the IIO at the incident scene, the chief constable must ensure that the scene is secured and that officers involved in the incident are segregated from each other,
    - officers involved in the incident must not communicate with each other about the incident, except as authorized by the IIO,
    - the IIO becomes the lead investigative agency, and the home police department has no investigative responsibility or authority, except as granted by IIO,
    - a witness officer must promptly make himself or herself available for an interview with the IIO investigator, and must promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident, and
    - a respondent officer may be – but is not compelled to be – interviewed by the IIO, and must in all cases promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident.
9. I recommend that the director recommends to the Criminal Justice Branch whether criminal charges should be laid, and if so, which charges, involving which officer or officers.
10. I recommend that the provincial Ombudsman have jurisdiction over the IIO.

2. Proposed enhancements to the Davies model

As I noted earlier, the landscape has changed significantly since Mr. Davies made his recommendations, and for that reason I have concluded that there is a need for several enhancements to his proposals.

a. Applicability to all of British Columbia

In light of the RCMP's new national policy to refer all serious police-related incidents to a provincially established investigative regime (where there is one), the civilian-based investigative body proposed for British Columbia must have province-wide jurisdiction; that is, in the 12 municipalities policed by the 11 municipal police departments, as well as in all the other municipalities and in all unorganized areas of the province that are policed by the RCMP under contract to the province.

b. Mandate

Mr. Davies explained (at p. 217) his rationale for limiting his recommendations to police-related deaths:

> Throughout this report I have limited my discussion to police-related *deaths*. I appreciate that it is sometimes only good fortune that separates serious injury from death, and that the conflict of interest that jeopardizes the integrity of police-related death investigations applies with equal force to investigations of police-related serious injuries. I note that in Ontario the mandate of the Special Investigations Unit extends to serious injuries and deaths involving municipal police (as well as the Ontario Provincial Police), and this mandate has been interpreted to include firearms injuries and deaths, custody injuries and deaths, motor vehicle injuries and deaths, and sexual assault.
>
> I have decided not to include the investigation of police-related serious injuries in my recommendations for several reasons. First, the fact pattern that was before me involved a police-related death. I concluded that conflict of interest probably contributed to what I find to be an unsatisfactory criminal investigation in that case, and I am willing to extrapolate from that incident the existence of a risk that conflict of interest could taint other police-related death investigations. However, without a firmer evidentiary basis, it would be imprudent for me to extrapolate any farther, to cases of serious injuries.
>
> Second, while I am confident that a new system is required and should be established for all municipal police departments without delay, there is merit in proceeding incrementally when it comes to defining the mandate of this new system. Prudence suggests that we begin with the most serious category of cases first. Then, after developing policies and practices, and gaining valuable on-the-ground experience, the decision can be made whether the mandate should be broadened and, if so, how much.

Persuasive as those reasons were at that time, the RCMP's new policy requires a reconsideration of what the proposed new investigative body's mandate should be. According to the RCMP, it will request an independent external investigation whenever:

- there is a serious injury or death of an individual involving an RCMP employee, or
- when it appears that an employee of the RCMP may have contravened a provision of the *Criminal Code* or other statute and the matter is of a serious or sensitive nature.

Logic dictates that the breadth of the mandate of the proposed new investigative body ought to be at least as extensive as the categories of offences that the RCMP wishes to refer to that body.

The RCMP's new policy is acknowledged to be an interim measure, and there will be ongoing consultation with provincial partners to provide for independent investigation and to support new legislative initiatives to enhance this important aspect of police accountability. With that in mind, in my view, there are several aspects of the RCMP's new policy that ought to be given greater specificity for a very practical reason. When a police-related incident occurs, the chief constable or commanding officer of the RCMP must be able to make an immediate determination whether it is the type of incident that must be referred to the independent investigative body; in other words, the circumstances in which discretion must be exercised should be eliminated as much as possible.

Consequently, in my view, the legislation establishing the proposed new investigative body should address the following matters.

> *i. Police-related incidents* – this is descriptive, but not particularly precise. Mr. Davies (speaking only of deaths) fleshed it out to encompass a wide variety of factual circumstances including (but not limited to) incidents in a police department jail cell, an incident resulting from an officer's use of force or a motor vehicle, or an incident arising from some other form of police interaction with the subject. I am attracted to recent amendments to the

Police Act[308] that have taken a different approach in articulating the types of matters that must (in most cases) be referred to an external police force for professional standards investigations:

(a) a person dies or suffers serious harm

  (i) while in the custody or care of a member of the municipal police department, or
  (ii) as a result of the operations of that municipal police department, or

(b) a person dies or suffers serious harm and the death or serious harm could be seen to be the result of

  (i) the conduct of any member of the municipal police department, or
  (ii) the operations of that municipal police department.

ii. Serious injury – The RCMP policy does not define this term. I am again attracted to the *Police Act's* definition of "serious harm:"

"serious harm" means injury that

(a) creates a substantial risk of death,
(b) causes serious disfigurement, or
(c) causes substantial loss or impairment of mobility of the body as a whole or of the function of any limb or organ.

iii. Other serious matters – the RCMP policy includes incidents in which an RCMP officer may have contravened a provision of the *Criminal Code* or other statute and the matter is of a serious or sensitive nature. This general language leaves much discretion to the commanding officer to decide whether the incident must be referred to the provincial investigative body – for example, what about an off-duty officer stopped for impaired operation of a motor vehicle, found in possession of marijuana, or accused of threatening a spouse? I appreciate that it is not possible to specify all the types of incidents that should be referred to the investigative body. Inevitably, it will be necessary to be as precise as possible, recognizing that discretion will have to be exercised to some extent. It seems to me that what is at stake here is public confidence in the police – if the decision of a home police department to conduct the criminal investigation may, in the minds of reasonable, informed members of the public, undermine confidence in the police, then the investigation ought to be referred to the independent investigative body.

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[308] *Police (Misconduct, Complaints, Investigations, Discipline and Proceedings) Amendment Act*, 2009 (Bill 7 - 2009), s. 89(1).

c. *Competence of investigators*

Mr. Davies was alive to this concern, stating (at pp. 219-220 and 234-235):

> One of the arguments that has been advanced historically to justify keeping the investigation of police-related deaths in-house (or at least within a neighbouring police department) is that they can be complex, requiring the special training and skills that only experienced police officers possess. For example, evidence must be collected and preserved, and statements from suspects must be taken, in a manner that will render them admissible at trial.
>
> While I agree that competence is crucial and that using currently serving experienced homicide investigators would promote competency, other jurisdictions have found other ways to address this concern, such as through specialized training programs and the employment of former or retired police officers for some purposes....
>
> I am satisfied that a civilian-based investigation team model eliminates concerns about conflict of interest and, with adequate resourcing, can conduct competent criminal investigations. Although the situation in British Columbia is significantly different from that in Ontario, we can learn much from SIU's growing pains. I am impressed with Mr. Adams' conclusion in his 2003 report, quoted earlier, that "all police and community representatives framed their proposals as intended to improve the SIU, not to replace it."

This is probably the most controversial aspect of the proposed new approach. Many in the policing community contend that only experienced police officers have the special training and skills required to competently conduct these sensitive criminal investigations. Others argue that these investigative skills can be taught or can be found in other investigative bodies, such as the military, government enforcement agencies, or self-governing professions.

In Ontario, the director of the Special Investigations Unit cannot be a current or former police officer, and investigators cannot be currently serving police officers. Former police officers may be hired as investigators, but they cannot investigate officers from their former police force. At the time Mr. Davies wrote his report, all three full-time investigative supervisors were former police officers, as were just under half of the full-time investigators. In 2008, the Ontario Ombudsman found that these former officers were steeped in police culture, and he stated that it was critical that SIU move swiftly away from the police ties that continue to hold it back from being a truly civilian oversight body.

In Alberta, the Alberta Serious Incident Response Team is led by a civilian director who is a lawyer and Crown prosecutor. Reporting to the director are a civilian assistant director, two civilian criminal analysts, four civilian investigators, and ten sworn police officers seconded from the Calgary and Edmonton municipal police departments and from the RCMP.

While Mr. Davies called for a civilian director, he made no specific recommendations respecting the professional backgrounds of the investigators.

I share Mr. Davies' view that the proposed independent investigative body can, if properly resourced, perform competently without reliance on police officers to serve as investigators. In my view it must, if it is to address the public's distrust of the police investigating themselves.

My only concern centres around timing – how quickly can British Columbia realistically develop an independent investigatory body that is, through and through, civilian? This is a profoundly important reform that must be done right, and if that takes some time, so be it. At the end of the day, this investigative body should, in my view, be entirely civilian. By that I mean that none of its management, supervisory staff, or investigators should have served anywhere in Canada as a police officer. I suggest that five years be the time frame within which that goal is achieved.

Between now and then, two interim measures are necessary:

- ***Staffing*** – from the day this new investigative body opens its doors, it will be operational, and it will have to be capable of responding immediately as police-related incidents are referred to it. For that reason, it may not be possible to initially staff the body completely with civilians. If that happens, in my view it would be acceptable, as a transitional measure, to employ former police officers, provided that:
    - they have not served as a police officer in British Columbia within the preceding five years,
    - they take no part in any investigation relating to a law enforcement agency in which they were employed,

  - they constitute no more than a minority of the investigators who are assigned to a particular investigation, and
  - their employment with the IIO expires by the end of the five-year transitional period.
- ***Training*** – depending on the skills and experience of candidates who apply for employment as investigators, it may be necessary to develop, through the Justice Institute, specialized training programs in matters such as investigative techniques, and scene of crime and other forensic analysis.

d. Charge assessment

In British Columbia, prosecutors in the Criminal Justice Branch of the Ministry of Attorney General decide whether criminal charges will be laid, based on the reports they receive from the investigating police officers. In normal circumstances, those charge assessment decisions are made at the local level. However, as Mr. Davies discussed in his report (at pp. 209-210), the practice is different in police-related incidents. The Branch policy states:

> In order to ensure that there is no perception of a conflict of interest and to maintain public confidence in the administration of criminal justice, the charge assessment decision on an allegation against a peace officer must be made by either Regional Crown Counsel or the Director, Legal Services.
>
> Regional Crown Counsel should make the charge assessment decision unless concerned that there could be an objectively reasonable perception of a conflict of interest or that the maintenance of public confidence in the administration of justice requires that the decision should be made at Headquarters. In either case, the matter should be referred to the Director, Legal Services for a charge assessment decision, pursuant to the procedure set out below.

Where there is an allegation that a peace officer's actions caused death, the policy requires that the Director, Legal Services provide a copy of the material to the Assistant Deputy Attorney General.

As noted earlier, Mr. Davies recommended that the director of the proposed new Independent Investigation Office would recommend to the Criminal Justice Branch whether criminal charges should be laid, and if so, which charges, involving which officer or officers. He added (at p. 240):

> The question of whether the director should be the one to approve criminal charges – rather than Crown Counsel – is an important one. I understand this to be the practice in Ontario, although I appreciate that in Ontario (as in most provinces), the police determine who is charged criminally – while in BC that determination is left to Crown Counsel. Because I have not had input on this issue from the Criminal Justice Branch, I may reconsider this recommendation if, at the conclusion of the litigation involving the branch, further information persuades me that a different approach is necessary. I reserve the right to consider, for instance, whether the IIO director should approve criminal charges, and also to what extent special prosecutors should be employed in such cases.

As indicated, in Ontario the director of SIU decides whether criminal charges will be laid against a police officer. When the director approves charges, the prosecutions are conducted by a Crown attorney in the Justice Prosecutions section of the Ministry of the Attorney General, which is responsible for prosecuting those in the justice system who are charged by any authority.

In Alberta, the director of the Alberta Serious Incident Response Team reviews the results of each investigation to ensure completeness and fairness. A report is then forwarded to the office of the Crown prosecutor, requesting an opinion on charges. The director will, after reviewing that opinion, decide what charges, if any, will result from the investigation.

Two issues arise. Who should make the charge assessment decision? If charges are approved, who should prosecute the police officer? In considering these questions, I return again to the pivotal concerns about conflict of interest, public distrust, and an undermining of public confidence in the police and in our justice system. In light of the explicitly stated concerns about perceptions of conflict of interest in the Criminal Justice Branch's policy cited earlier, it would in my view be inappropriate for lawyers within that branch to make charge assessment decisions in police-related incidents. In such sensitive matters, it only takes a perception of conflict of interest to undermine public confidence. I am also uncomfortable with the director of the independent investigative body making charge assessment decisions. British Columbia has a long and respected tradition of keeping the police investigatory and the quasi-judicial charge assessment roles separate. It would in my view be a regrettable blurring of those roles for the director of the independent investigatory body to make charge assessment decisions.

For these reasons, I have concluded that in every police-related incident that is assigned to the proposed independent investigatory body, a special prosecutor should be appointed in accordance with the *Crown Counsel Act*, R.S.B.C. 1996, c.87. The special prosecutor should make the charge assessment decisions and should, if charges are approved, assume conduct of the prosecution.

D. RECOMMENDATION

In preparing my recommendation, I have adopted Mr. Davies' framework and have made changes to it that I consider necessary in light of the changed landscape I discussed earlier.

Recommendation 8

I recommend that:

a. British Columbia develop a civilian-based criminal investigative body, which I suggest be named the Independent Investigation Office (IIO).

b. The IIO be mandated to investigate all police-related incidents occurring throughout the province, in which:

- "police-related incidents" include, but are not necessarily limited to, incidents:
    - in which a person dies or suffers serious harm:
        - i. while in the custody or care of a municipal police officer or RCMP officer, or
        - ii. the death or serious harm could be seen to be the result of the conduct of any municipal police officer or RCMP officer, or
    - which involve possible contravention, by a municipal police officer or RCMP officer, of:
        - i. any provision of the *Criminal Code*, or

    - ii. any other federal or provincial statute that, if the incident were investigated by a police officer, might in the minds of reasonable, informed members of the public undermine confidence in the police.
- "serious harm" means injury that:
    - ○ creates a substantial risk of death,
    - ○ causes serious disfigurement, or
    - ○ causes substantial loss or impairment of mobility of the body as a whole or of the function of any limb or organ.

c. The IIO be accountable to the Ministry of Attorney General.

d. The IIO be led by a director who is neither a current nor former police officer, appointed by Order-in-Council for a fixed, renewable term of five or six years.

e. No member of the IIO shall have served anywhere in Canada as a police officer.

f. Notwithstanding para. (e), during the first five years of operations, the IIO may include as members former police officers, provided that:

- they have not served as a police officer in British Columbia, within the preceding five years,
- they take no part in any investigation relating to a law enforcement agency in which they were employed,
- they constitute no more than a minority of the investigators who are assigned to a particular investigation, and
- their employment with the IIO expires by the end of the five-year transitional period.

g. To ensure the IIO's unquestioned authority to act, its essential powers be entrenched in legislation, such as:

- the IIO director and investigators have the status of peace officers,
- the chief constable or commanding officer of the RCMP of the jurisdiction in which a police-related death occurs must immediately advise the IIO of the incident,
- pending arrival of the IIO at the incident scene, the chief constable or commanding officer of the RCMP must ensure that

the scene is secured and that officers involved in the incident are segregated from each other,

- officers involved in the incident must not communicate with each other about the incident, except as authorized by the IIO,
- the IIO becomes the lead investigative agency, and the home police department or RCMP has no investigative responsibility or authority, except as granted by IIO,
- a witness officer must promptly make himself or herself available for an interview with the IIO investigator, and must promptly deliver to the IIO all notes, reports, and other investigative materials relevant to the incident, and
- a respondent officer may be — but is not compelled to be — interviewed by the IIO, and must in all cases promptly deliver to the IIO all notes, reports, and other investigative materials relevant to the incident.

h. In every police-related incident assigned to the IIO, a special prosecutor be appointed in accordance with the *Crown Counsel Act*.

i. The provincial Ombudsman have jurisdiction over the IIO.

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APPENDIX A

THOMAS R. BRAIDWOOD, Q.C., COMMISSIONS OF INQUIRY PURPOSE AND TERMS OF REFERENCE

Definitions

1 In this Order:

"Conducted energy weapon" means a weapon or device commonly referred to as a TASER®;

"Mr. Dziekanski" means Mr. Robert Dziekanski, who died at the Vancouver International Airport on October 14, 2007;

"RCMP" means the Royal Canadian Mounted Police Force continued under the *Royal Canadian Mounted Police Act (Canada).*

Establishment of two commissions

2 (1) A study commission, called the Thomas R. Braidwood, Q.C., Study Commission, is established under section 2 of the *Public Inquiry Act* to inquire into and report on the use of conducted energy weapons by the following in the performance of their duties and the exercise of their powers:

(a) constables of police forces of British Columbia, other than the RCMP;
(b) sheriffs under the *Sheriff Act*;
(c) authorized persons under the *Correction Act*.

(2) A hearing and study commission, called the Thomas R. Braidwood, Q.C., Hearing and Study Commission, is established under section 2 of the *Public Inquiry Act* to inquire into and report on the death of Mr. Dziekanski.

(3) Thomas R. Braidwood, Q.C., is the sole commissioner of each of the commissions established under this section.

Purposes of the commissions

3 (1) The purpose of the study commission established under section 2 (1) is to make recommendations respecting the appropriate use of conducted energy weapons by constables, sheriffs and authorized persons referred

to in section 2 (1), in the performance of their duties and the exercise of their powers.

(2) The purposes of the hearing and study commission established under section 2 (2) are as follows:

(a) to provide Mr. Dziekanski's family and the public with a complete record of the circumstances of and relating to Mr. Dziekanski's death;
(b) to make recommendations referred to in section 4 (2) (c).

Terms of reference

4 (1) The terms of reference of the inquiries to be conducted by the study commission established under section 2 (1) are as follows:

(a) to review current rules, policies and procedures applicable to constables, sheriffs and authorized persons referred to in section 2 (1) in respect of their use of conducted energy weapons and their training and re-training in that use;
(b) to review research, studies, reports and evaluations respecting the safety and effectiveness of conducted energy weapons when used in policing and law enforcement in British Columbia and in other jurisdictions;
(c) to make recommendations respecting

(i) the appropriate use of conducted energy weapons by constables, sheriffs and authorized persons referred to in section 2 (1) in the performance of their duties and the exercise of their powers, and
(ii) the appropriate training or re-training of those constables, sheriffs and authorized persons in that use of conducted energy weapons;

(d) to submit a report to the Attorney General on or before June 30, 2008*.

(2) The terms of reference of the inquiries to be conducted by the hearing and study commission under section 2 (2) are as follows:

(a) to conduct hearings, in or near the City of Vancouver, into the circumstances of and relating to Mr. Dziekanski's death;
(b) to make a complete report of the events and circumstances of and relating to Mr. Dziekanski's death, not limited to the actual cause of death;

(c) to make recommendations the commissioner considers necessary and appropriate;

(d) to submit a report to the Attorney General on or before a date to be determined by the Attorney General in consultation with the Commissioner.

* Amended by OIC 882/2008 to June 30, 2009.

APPENDIX B

COMMISSION PERSONNEL

Commissioner

Hon. Thomas R. Braidwood, Q.C.

Counsel

Art Vertlieb, Q.C., Commission Counsel

Patrick McGowan, Associate Commission Counsel

Keith Hamilton, Q.C., Policy Counsel

Sharon Samuels, Research Counsel

Dolores Holmes, Advisor

Staff

Chan, Jennifer, Legal Researcher

Cheung, Christine, Administration Assistant

Cutler, Erin, Legal Researcher

Flannigan, Jenna, Legal Researcher

Lunn, John, Hearing Coordinator

McKeachie, Jessica, Legal Student Assistant

Perra, Leo, Executive Director

Ryan, Cynthia, Research Librarian and Documents Manager

Stooshnov, Cathy, Manager, Finance and Administration

Contractors

Kingdon, Scott, Webmaster

Freimond, Chris, Media Communications

McEachern, Melanie, Transcription and Media Services

Rainaldi, Linda, Editor

Rowlands, Christine, Proofreader

APPENDIX C

LIST OF SUBMITTERS

- Baglow, John
- Barz, Don
- Battershill, Jim
- Beil, Alison
- Boudreau, Wayne
- Breen, Sally
- Burns, Clayton
- Canadian Polish Congress
- Clapci, Tony
- Dormer, Sandra
- Duern, James
- Edwards, Robert
- Elias, James
- Farrell, Norman
- Fearn, Bob
- Finnigan, Linda
- Fisher, Glen T.
- Fulton, RG
- Guetta, Arnold
- Hill, James
- Hills, Ken
- Holden, Peter J.
- Jaworski, Mark
- Johnston, Kevin
- Krzyzanowski, Tomasz
- Kudyba, Olga
- LaBelle, Laura
- Langevin, Trevor
- Mackenzie, Dave
- Martell, R.T. (Bob)
- Mason, Derek
- Massine, Mike
- Matheson, Tim
- McCaskill, Ken
- McConnell, Roy L.
- Morley, Richard P.
- Morrison, Colin
- Murray, Shawna
- Rigal, W.M. (Dr.)
- Robinson, Mike
- Ronback, James
- Ross, D.J. (Col.)
- Schweinsberg, Hans F.
- Seager, Rodger
- Spicer, Phil
- Stringer, Kathleen A.
- Tagish, Peter
- Violini, Jay
- Yerex, Roy
- Zoffmann, Elisabeth
- Watson, Dorothy
- Watson, Ron

APPENDIX C

APPENDIX D

LIST OF WITNESSES

Monday, January 19, 2009

BUETTNER, Adolf (Condor Airlines)

GONZALEZ, Jesus Fernandez (Lufthansa German Airlines)

HEWER, Christiane (passenger on flight DE6070)

HUNTER, Patricia (Vancouver Airport Authority)

Tuesday, January 20, 2009

GROSS, Trevor (Canada Border Services Agency)

KULLAR, Monica (Canada Border Services Agency)

Wednesday, January 21, 2009

HUTCHINSON, Richard Gerald (driver of Zofia Cisowski)

RICHARDS, Christopher Arthur (Airport customer service)

SULLIVAN, Janet (Airport customer service)

WIDINER, Julene Ann (Lufthansa baggage services)

Thursday, January 22, 2009

BHARYA, Kal (Canada Border Services Agency)

ZADRAVEC, Tina (Canada Border Services Agency)

Monday, January 26, 2009

AGTEREN, Juliette Van (Canada Border Services Agency officer)

CURRIE, Alexandra (Canada Border Services Agency, Acting Superintendent)

MCKENZIE, Kelly Leanne (Canada Border Services Agency officer)

Tuesday, January 27, 2009

CHAPIN, Adam (Canada Border Services Agency)

GRAEME, Kirby (Richmond Fire and Rescue)

Wednesday, January 28, 2009

DURANLEAU, Sonia (Richmond Fire and Rescue)

GRAEME, Kirby (Richmond Fire and Rescue)

Thursday, January 29, 2009

BAGGIO, Nancy (Vancouver Airport Authority) (with YVR security videos)

DURANLEAU, Sonia (Richmond Fire and Rescue)

PUREWAL, Sonya (Canada Border Services Agency)

Monday, February 02, 2009

BARSKI, Kris

DHARI, Joginder (Vancouver Airport Authority)

Tuesday, February 03, 2009

CANZON, Jame Glenn (witness – cleaning staff)

MELTZER, Lorne (eye witness)

Wednesday, February 04, 2009

AGRAVIADOR, Servideo (Vancouver Airport Authority)

ASHRAFINIA, Sima (eye witness)

MELTZER, Lorne (eye witness)

Thursday, February 05, 2009

ASHRAFINIA, Sima (eye witness)

BOSNJAK, Marija (Horizon Air)

KULA, Alison (Horizon Air)

Monday, February 09, 2009

DEZIEL, Genevieve (Horizon Air)

JORSSEN, Robert (civilian with RCMP)

KULA, Alison (Horizon Air)

Tuesday, February 10, 2009

BYL, Doug (Vancouver Airport Authority)

JORSSEN, Robert (civilian with RCMP)

LE, Nick (eye witness)

VRBA, Karol (City of Richmond)

Wednesday, February 11, 2009

HANSON, Carla (Vancouver Airport Authority)

STALLER, Heather (Vancouver Airport Authority)

VRBA, Karol (City of Richmond)

Thursday, February 12, 2009

RUDEK, Lance (Vancouver Airport Authority)

STALLER, Heather (Vancouver Airport Authority)

Monday, February 16, 2009

ARORA, Sidharth (Vancouver Airport Authority)

D'SA, Fabian (Vancouver Airport Authority)

ENCHELMAIER, Trevor (Vancouver Airport Authority)

Tuesday, February 17, 2009

ENCHELMAIER, Trevor (Vancouver Airport Authority)

GINTER, Robert (Vancouver Airport Authority)

Wednesday, February 18, 2009

CALDWELL, Andrew (Vancouver Airport Authority)

CAMERON, Glen (Richmond Fire and Rescue)

GINTER, Robert (Vancouver Airport Authority)

KOPP, Brent (Richmond Fire and Rescue)

Thursday, February 19, 2009

GREENFIELD, Sandi (E-Comm)

Monday, February 23, 2009

Cst. RUNDEL, Gerry (RCMP)

Tuesday, February 24, 2009

Cst. RUNDEL, Gerry (RCMP)

Wednesday, February 25, 2009

Cst. BENTLEY, Bill (RCMP)

Cst. RUNDEL, Gerry (RCMP)

Thursday, February 26, 2009

Cst. BENTLEY, Bill (RCMP)

Monday, March 02, 2009

Cst. MILLINGTON, Kwesi (RCMP)

Tuesday, March 03, 2009

Cst. MILLINGTON, Kwesi (RCMP)

Wednesday, March 04, 2009

Cst. MILLINGTON, Kwesi (RCMP)

Monday, March 23, 2009

Cpl. ROBINSON, Benjamin (RCMP)

Tuesday, March 24, 2009

Cpl. ROBINSON, Benjamin (RCMP)

Wednesday, March 25, 2009

Cpl. ROBINSON, Benjamin (RCMP)

Thursday, March 26, 2009

EGLI, Mike (BC Ambulance Service)

MACIAK, Allan (BC Ambulance Service)

RANDELL, Miles (BC Ambulance Service)

VAN HOUTEN, Ron (BC Ambulance Service)

Monday, March 30, 2009

KOSOWSKA, Iwona (witness from Poland by video/teleconference)

Tuesday, March 31, 2009

CZELWINSKA, Magda (witness from Poland by video/teleconference)

KRASINSKI, Ryszard (witness from Poland by video/teleconference)

Thursday, April 02, 2009

DYLSKI, Robert (witness from Poland by video/teleconference)

Tuesday, April 14, 2009

DORE, Peter (Airport employee)

SAMBROOK, Gregory Francis (Airport Operations Manager)

Wednesday, April 15, 2009

Cpl. BASRA, Nycki (RCMP)

Cst. HOIVIK, Paul (RCMP)

SAMBROOK, Gregory Francis (Airport Operations Manager)

Thursday, April 16, 2009

Sgt. FAWCETT, Brad (Vancouver Police Department)

Monday, April 20, 2009

Cst. BALTZER, Craig (Delta Police Department)

CHAPIN, Adam (Canada Border Services Agency)

Sgt. FAWCETT, Brad (Vancouver Police Department)

Tuesday, April 21, 2009

Cst. BALTZER, Craig (Delta Police Department)

Sgt. LEMAITRE, Pierre (RCMP)

Wednesday, April 22, 2009

Cpl. CARR, Dale (RCMP Media Relations Officer)

Thursday, April 23, 2009

Cpl. GILLIS, Gregg (RCMP)

Monday, April 27, 2009

Dr. LEE, Charles (Pathologist)

Tuesday, April 28, 2009

Dr. LEE, Charles (Pathologist)

Dr. PANESCU, Dorin (Electrical Engineer) (video/teleconference)

Dr. SWERDLOW, Charles (Cardiac Electrophysiologist) (video/teleconference)

Wednesday, April 29, 2009

Dr. BUTT, John (Pathologist)

Thursday, April 30, 2009

Dr. BUTT, John (Pathologist)

Dr. MARTZ, Walter (Toxicologist)

Monday, May 04, 2009

Dr. LU, Shao-Hua (Psychiatrist)

Tuesday, May 05, 2009

HILTON, Brian (CBSA)

KOONER, Binder (CBSA)

Wednesday, May 06, 2009

Insp. LIGHTFOOT, Troy (RCMP)

Supt. RIDEOUT, Wayne (RCMP)

Thursday, May 07, 2009

EHRENHOLZ, Don (YVR Operations)

Dr. KERR, Charles Robert (Cardiologist)

Friday, May 08, 2009

Dr. TSENG, Zian (Cardiac Electrophysiologist)

Monday, May 11, 2009

Cpl. GILLIS, Gregg (RCMP)

Dr. HO, Jeffrey (Emergency Medicine) (by teleconference)

Tuesday, May 12, 2009

Cpl. GILLIS, Gregg (RCMP)

Dr. WEBSTER, Michael Charles (Psychologist)

Wednesday, May 13, 2009

Dr. CHAMBERS, Gordon Keith (Epidemiologist)

Dr. WEBSTER, Michael Charles (Psychologist)

Thursday, May 14, 2009

Dr. CHAMBERS, Gordon Keith (Epidemiologist)

Dr. KERR, Charles Robert (Cardiologist)

Thursday, May 21, 2009

Dr. JANKE, Paul (Psychiatrist)

Friday, May 22, 2009

NICKEL, Orville (Use-of-Force Expert) (via teleconference)

Monday, May 25, 2009

FREDERICKS, Grant (Forensic Video Analyst)

HIRD-RUTTER, Mark (Certified Photogrammetrist)

Tuesday, May 26, 2009

MACINNIS, Duane (Professional Engineer)

Tuesday, September 22, 2009

Chief Superintendent BENT, Dick (RCMP)

Assistant Commissioner MACINTYRE, Al (RCMP)

Supt. RIDEOUT, Wayne (RCMP)

Wednesday, September 23, 2009

Ms. CHURCHILL-BROWNE, Gracie (Interpreter by independent contract to CBSA)

Mr. JUBBER, John (United Airlines employee)

Staff Sergeant WRIGHT, Doug (RCMP)

APPENDIX E

PRACTICE AND PROCEDURE DIRECTIVE FOR EVIDENTIARY HEARINGS [AUTHORIZED BY *PUBLIC INQUIRY ACT*, S. 9(1)]

AUGUST 12, 2008

Definitions

1 In this directive,
"Act" means the *Public Inquiry Act*, S.B.C. 2007, c. 9,
"Commission" means the hearing and study commission established under section 2(2) of the Thomas R. Braidwood, Q.C., Commissions of Inquiry Order,
"record" includes books, documents, maps, drawings, photographs, letters, vouchers, papers and any other thing on which information is recorded or stored by any means whether graphic, electronic, mechanical or otherwise.

Purpose of the evidentiary hearings

2 The Commissioner will inquire into those matters set out in section 4(2) of the Order establishing the Commission. On the basis of oral and documentary evidence tendered during the evidentiary hearings, the Commissioner will make findings of fact and may make a finding of misconduct against a person or make a report that alleges misconduct by a person. The Commissioner's findings of fact or findings of misconduct cannot be taken as findings of criminal or civil liability.

Public and media access to evidentiary hearings

3 Subject to Rule 4, the Commission must

(a) ensure that evidentiary hearings are open to the public, either in person or through broadcast proceedings, and
(b) give the public access to information submitted in an evidentiary hearing (see *Public Inquiry Act*, s. 25).

4 The Commissioner may, by order, prohibit or restrict a person or class of persons, or the public, from attending all or part of an evidentiary hearing, or from accessing all or part of any information provided to or held by the Commission,

(a) if the government asserts privilege or immunity over the information under section 29 of the Act,
(b) for any reason for which information could or must be withheld by a public body under sections 15 to 19 and 21 to 22.1 of the Freedom of Information and Protection of Privacy Act,
(c) if the Commissioner has reason to believe that the order is necessary for the effective and efficient fulfillment of the Commission's terms of reference (see *Public Inquiry Act*, s. 15(1)), or
(d) if the Commissioner is satisfied that such an order would make available to the Commission evidence that would otherwise not be available due to a privilege under the law of evidence.

5 In making an order under Rule 4, the Commissioner must not unduly prejudice the rights and interests of a participant against whom a finding of misconduct, or a report alleging misconduct, may be made (see *Public Inquiry Act*, s. 15(2)).

Video and audio recording of the evidentiary hearing proceedings

6 The Commissioner may impose restrictions on the video and audio recording of the evidentiary hearing proceedings and may, on application, order that there be no video or audio recording of some or all of a witness's testimony.

Reporting the proceedings

7 The public and media may report the evidentiary hearing proceedings that are open to the public, except for testimony and/or submissions in respect of which the Commissioner has ordered that they shall not be published.

Application to participate in the evidentiary hearings

8 A person may apply to be a participant by applying to the Commission in the manner and form it requires. The application must set out the basis upon which participation is sought, and the extent and nature of the participation sought.

9 The Commissioner may accept an applicant as a participant after considering all of the following:

(a) whether, and to what extent, the person's interests may be affected by the findings of the commission,
(b) whether the person's participation would further the conduct of the inquiry,

(c) whether the person's participation would contribute to the fairness of the inquiry (see *Public Inquiry Act*, s. 11(4)).

Powers respecting participants

10 Subject to Rule 13, the Commissioner may make orders respecting

(a) the manner and extent of a participant's participation,
(b) the rights and responsibilities of a participant, if any, and
(c) any limits or conditions on a participant's participation (see *Public Inquiry Act*, s. 12(1)).

11 In making an order under Rule 10, the Commissioner may

(a) make different orders for different participants or classes of participants, and
(b) waive or modify one or more of his orders as necessary (see *Public Inquiry Act*, s. 12(2)).

12 In making an order under Rule 10, the Commissioner must ensure that a participant who responds to a notice under section 11(2) of the Act has a reasonable opportunity to be heard by the Commissioner before the Commissioner makes a finding of misconduct against the participant, or makes a report that alleges misconduct by that participant (see *Public Inquiry Act*, s. 12(3)).

Rights of participants

13 A participant may

(a) participate on his or her own behalf, or
(b) be represented by counsel or, with the approval of the Commissioner, by an agent (see *Public Inquiry Act*, s. 13(1)).

14 A participant

(a) has the same immunities as a witness who appears before the court, and
(b) is considered to have objected to answering any question that may

  (i) incriminate the participant in a criminal proceeding, or
  (ii) establish the participant's liability in a civil proceeding (see *Public Inquiry Act*, s. 13(2)).

Confidentiality of records

15 Commission Counsel shall not provide a record to counsel, a participant or a witness until that person has delivered to Commission Counsel a signed undertaking, in a form approved by the Commissioner, that all records disclosed by the Commission will be used solely for the purposes of the Inquiry.

16 Counsel for a participant or a witness shall not provide a record to the participant or witness until the participant or witness has delivered to counsel a signed undertaking, in a form approved by the Commissioner, and counsel has delivered that signed undertaking to Commission Counsel.

17 The Commissioner may:

(a) impose restrictions on the use and dissemination of records,
(b) require that a record that has not been entered as an exhibit in the evidentiary proceedings, and all copies of the record, be returned to the Commission, and
(c) on application, release counsel, a participant or a witness, in whole or in part, from the undertaking in relation to any record, or may authorize the disclosure of a record to another person.

Records

18 A participant must, at the earliest opportunity and in any event at least ten days before using a record in an evidentiary hearing or tendering it as an exhibit, deliver a copy of the record to Commission Counsel.

Public access to records

19 Unless the Commissioner orders otherwise:

(a) a record within the Commission's control that has not been entered as an exhibit is not available for public inspection or copying, and
(b) a record that has been entered as an exhibit may be inspected by the public and the media. The Commission will determine the circumstances in which a charge will be imposed for copying records.

Applications to the Commissioner

20 A participant may apply to the Commissioner for an order by:

(a) preparing the application in writing,
(b) attaching to the application any supporting materials, and
(c) delivering the application and supporting materials to the Commission by e-mail, to cathy.stooshnov@braidwoodinquiry.ca in Microsoft Word or *.pdf format.

21 An applicant must deliver the application for an order to the Commission at least two days before the application is to be heard.

22 A participant who wishes to receive notice of an application shall provide the Commission with an e-mail address for delivery.

23 The Commission shall promptly deliver the application and supporting materials, by e-mail, to each other participant who has provided the Commission with an email address for delivery.

24 Any other participant may file written materials in relation to an application made under Rule 20.

25 The Commissioner may make an order based on the written material filed or, at his discretion, after hearing oral argument.

Applications for further disclosure of a record

26 A participant may seek disclosure of a record from another person ("record holder") by asking Commission Counsel, in writing, to use the powers of the Commission to obtain the record.

27 The request must state:

(a) the reasons the participant believes the record holder possesses the record, and
(b) the reasons the participant believes the record is relevant to a matter before the Commission.

28 If Commission Counsel accepts the request, Commission Counsel will attempt to obtain the record.

29 If Commission Counsel rejects the request, Commission Counsel shall notify the participant, and the participant may apply to the Commissioner, in accordance with Rules 20 to 23, for an order respecting the request.

30 When the participant applies to the Commissioner under Rule 29, the Commission shall deliver the application and any supporting materials to

the record holder, and to each other participant who has provided the Commission with an e-mail address for delivery.

31 The record holder and any other participant may file written materials in relation to an application made under Rule 29.

32 Unless the Commissioner orders otherwise, the procedures set out in Rules 26 to 31, in relation to a particular witness, should whenever possible be completed before that witness commences his or her testimony.

Witnesses

33 Each participant shall provide to Commission Counsel at the earliest opportunity the name and address of any person who the participant believes should be called as a witness during the evidentiary hearings, with a statement of the subject matter of their proposed testimony, their experience and background, and the estimated length of their testimony.

34 The following rules apply to witnesses:

(a) Commission Counsel shall decide who shall be called as a witness at the evidentiary hearings,
(b) Subject to Rule 35, Commission Counsel shall call and examine witnesses on behalf of the Commission, and may adduce evidence by way of both leading and non-leading questions,
(c) each witness called shall, before testifying, be sworn or affirm,
(d) each witness who testifies may during his or her testimony be represented by counsel or, with the approval of the Commissioner, by an agent,
(e) the Commissioner may, on application by a participant, permit a participant to cross-examine a witness to the extent of that participant's interest. If the participants are unable to agree on an order of cross-examination, the Commissioner will determine the order,
(f) subject to Rule 35, counsel for a participant is entitled to examine that participant last, regardless of whether or not counsel is also representing another participant,
(g) after Commission Counsel has called all witnesses on behalf of the Commission, a participant may apply to the Commissioner for permission to call a witness and, if permission is granted, subrules (c) to (e) apply to each witness called by a participant.
(h) Commission Counsel has the right to re-examine any witness who has testified.

35 Counsel for a witness may apply to the Commissioner for permission to lead that witness's examination in chief. If permission is granted, counsel will examine the witness in accordance with the normal rules governing the examination of one's own witness in court proceedings, unless the Commissioner directs otherwise.

Power to accept information

36 The Commissioner may receive and accept:

(a) information that he considers relevant, necessary and appropriate, whether or not the information would be admissible in any court (see *Public Inquiry Act*, s. 14(1)), and
(b) a witness's evidence by way of affidavit or written statement, or by audio or video conference.

37 Without limiting Rule 10, the Commissioner may exclude anything unduly repetitious (see *Public Inquiry Act*, s. 14(2)).

38 Nothing in Rule 36 overrides the provisions of any Act expressly limiting the extent to which or purposes for which any oral testimony, records or things may be admitted or used in evidence (see *Public Inquiry Act*, s. 14(3)).

39 A person cannot be compelled to disclose in an evidentiary hearing anything that, in any court, would be privileged under the law of evidence (see *Public Inquiry Act*, s. 22(2)).

Final submissions

40 Commission Counsel, and each participant authorized to do so, may make final oral and written submissions to the Commissioner on any issue within the Commission of Inquiry's terms of reference.

41 The Commissioner may set time limits on oral submissions, and page limits on written submissions.

The Commission's process

42 Subject to the Act and the Commission's Terms of Reference, the Commission has the power to control its own process (see *Public Inquiry Act*, s. 9(1)).

Participant's failure to comply with this directive

43 Without limiting any other powers of enforcement, if a participant fails to comply with this directive, including any time limits specified for taking any actions, the Commissioner, after giving notice to the participant, may do any of the following:

(a) schedule a meeting or hearing,
(b) continue with the inquiry and make a finding or recommendation based on the evidence before him, with or without providing an opportunity for submissions from that participant,
(c) make any order necessary for the purpose of enforcing this directive (see *Public Inquiry Act*, s. 17).

Commissioner's discretion

44 The Commissioner retains a residual discretion to amend, add to, vary or depart from any of the Rules in this Directive for the effective conduct of the evidentiary hearings.

GLOSSARY

Acidosis—an increase in the acidity (concentration of hydrogen ions) in the blood, decreasing the pH level below the normal range of 7.35 to 7.45

Adrenergic—pertaining to sympathetic nerve fibres of the autonomic nervous system that liberate adrenaline or noradrenaline

AED—automated external defibrillator, a portable electronic device that automatically diagnoses certain cardiac arrhythmias and is used to treat them through the application of electricity (defibrillation) to re-establish a normal heart rhythm

Agonal breathing—an abnormal breathing pattern typically characterized by shallow, irregular, and laboured breaths, and may be accompanied by gasping and strange vocalizations

Aneurysm—a localized, blood-filled sac caused by disease or weakness in the wall of a blood vessel, typically found in arteries of the brain or heart

Arrhythmia—a variation from the normal rhythm of the heart

Asystole—a state of no cardiac electrical activity, hence no heartbeat

Ataxia—a neurological condition associated with the gross lack of coordination of muscle movements resulting from a dysfunction of parts of the nervous system that control movement

Autonomic hyperactivity—overactivity of the autonomic nervous system that may be caused on by a number of factors, including withdrawal from alcohol or other stimulants. See also "autonomic instability"

Autonomic instability—instability of the autonomic nervous system that may be caused by a number of factors. For example, patients suffering from delirium, a medical, physiological response to external insults, may exhibit autonomic instability with symptoms that may include rapid breathing, changes in perception, sweating, increased heart rate, and unstable blood pressure.

Bipolar—a spectrum of mood disorders that can shift between depression and abnormally elevated mood or mania

Bradyarrhythmia—a heart rhythm in which the heart rate falls below 60 beats per minute

Bradycardia—a heart rate below 60 beats per minute

CAPRA model—an RCMP model designed to increase one's understanding of the RCMP Community Policing Problem Solving Model, CAPRA (C = Clients, A = Acquire/Analyse Information, P = Partnerships, R = Response, A = Assessment of Action Taken)

Cardiac dysrhythmia—an abnormality in the rate, regularity, or activation sequence of the heartbeat

Cardiopulmonary resuscitation (CPR)—a technique to artificially restore oxygenation and cardiac output through external manipulation

Catecholamines—a class of hormones, including adrenaline, which are released from the adrenal glands, often associated with the "fight or flight" response

Cerebellar vermis—the narrow structure between the hemispheres of the cerebellum, a region of the brain that plays an important role in the integration of sensory perception, coordination, and motor control

CEW—conducted energy weapon. See "conducted energy weapon"

Commotio cordis—a sudden disturbance to the heart rhythm resulting from a sharp and strong nonpenetrating blow to the chest area, occurring often in sports events

Conducted energy weapon—an electrical device (weapon) that discharges a high voltage, low amperage current that causes extreme pain and/or neuromuscular incapacitation

Congestive heart failure—a condition in which the heart cannot pump enough blood to supply the body's tissues with sufficient oxygen

Contralateral positioning—positioning on corresponding parts of opposite sides.

Coronary ischemia—a condition characterized by reduced or insufficient blood supply to the heart muscle

Cyanosis—a bluish discoloration of the skin usually caused by a shortage of oxygen in the blood

Defibrillation—a treatment for cardiac arrhythmias involving the delivery of an electrical shock to the heart to stabilize the heart rhythm

Defibrillator—See "AED"

Delirium tremens—an acute episode of delirium, commonly known as the DTs, usually related to the withdrawal from alcohol or drugs and often involving episodes of shaking, agitation, and other signs of autonomic instability

Dopaminergic—pertaining to the neurotransmitter dopamine

E-Comm—an Emergency Communications service for southwest British Columbia

Electrocardiogram (ECG or **EKG)**—a graphic illustration of the electrical activity of the heart

Electrolyte—a substance (typically a solution) containing free ions that make it electrically conductive

Electrophysiology—the study of the electrical properties and electrical activity of the body

Endotracheal intubation—a medical procedure in which a tube is placed into the trachea (windpipe) to protect an airway; often used to provide a means of mechanical ventilation

Excited delirium—a controversial term used to describe a person who is highly agitated and may be under the influence of stimulants or drugs

Glycolysis—a metabolic process for the breakdown of glucose and production of energy

Hemodynamically stable—a condition where blood flow or circulation is normal

Homeostasis—the innate ability and need of the body to maintain a stable, constant physiological condition

Hyperadrenergic—pertaining to overactivity of the adrenergic system

Hyperkalemia—a condition characterized by high levels of potassium in the blood

Hyperreflexia—a condition where reflexes are over-responsive or overactive

Hyperthermia—a condition where the body absorbs or produces excessive heat, often associated with failed thermoregulation

Hypertrophic cardiomyopathy—a condition characterized by the abnormal thickening of the heart muscles (myocardium)

Hypocalcemia—a condition characterized by low levels of available calcium in the blood

Hypoxia—a condition characterized by shortage of oxygen in the body, or an area of the body

IHIT—Integrated Homicide Investigation Team

IM/IM—Incident Management/Intervention Model

Implanted cardiac defibrillator—a small implantable electronic device that detects certain cardiac arrhythmias and treats them by delivering a shock of electricity to the heart

Intercostal muscles—a group of muscles that run between and are connected to the ribs

Interstitial—pertaining to the interstices (the area between tissues and organs)

Ipsilateral positioning—positioning on the same side

Joule—a unit of electrical energy equivalent to the work required to produce one watt of power for one second

Lethal cover, lethal force overwatch—the practice of at least one police officer having her/his firearm ready during an incident while another officer is using less lethal methods

Muscular tetany—the involuntary contraction of muscles

Myocardial infarction—commonly known as a heart attack, occurs when the blood and oxygen supply to the heart or a part of the heart is interrupted

Myocardium—a thick layer of muscles forming the heart wall

National Use of Force Framework—a graphic illustration of when different levels of force are appropriate

Neuromuscular incapacitation—the loss of muscular control caused by stimulation of the sensory and motor nerves

Non-arrhythmogenic mechanism—a mechanism that does not promote or produce arrhythmia

P-wave—in electrocardiography, the wave representing contraction of the upper chambers of the heart (atria) on an ECG

Pericardiocentesis—a medical procedure to remove fluid from the sac surrounding the heart

Petechia—a small red or purple spot on the surface of the body caused by minor hemorrhage or break of blood vessels

Pepper spray—a chemical spray irritating and painful to the eyes. Also known as oleoresin capsicum or OC spray

Photogrammetry—a measurement technique that uses photographs to determine the properties of objects, such as their distance or size, etc.

Pixel—the smallest unit of a picture, referred to in the measurement of the resolution of a digital image

Post hoc, ergo propter hoc—a Latin term translated approximately as "after this, therefore because of this," used to illustrate the fallacy of assuming a causal link between two events based on their chronological correlation

Probe mode—refers to the mode of conducted energy weapon use whereby electricity is applied through two "hook-lock" probes discharged from the weapon

Psychomotor agitation—unintentional or purposeless motions, such as pacing or tapping, which may be caused by mental tension or anxiety

Pulsus alternans—a condition where the pulse fluctuates between strong and weak beats

Push-stun mode—refers to the mode of conducted energy weapon use whereby electricity is applied through two terminals at the end of the weapon, held firmly against the subject

QRS wave—an ECG representation of the contraction of the ventricles

Radial pulse—a pulse reading taken of the radial artery, typically at the wrist

Renal—pertaining to the kidney

Rhabdomyolysis—the breakdown of muscle, which releases cell components into the blood that are damaging to the kidneys and may eventually cause renal failure

Schizophrenia—a mental disorder whereby the individual has a perceptual difficulty that may be expressed through hallucinations, paranoia, or delusions

Sinus rhythm—an ECG representation of a normal heart rhythm

Spark test—a test of a conducted energy weapon that involves firing the device without a cartridge in place, to ensure that it produces an electrical current

Sympathetic-adrenal-medulla—a portion of the adrenal gland that produces adrenaline in response to stressors, as part of the "fight or flight" response

Sympathetic nervous system—a part of the autonomic nervous system that regulates many of the body's processes, including the "fight or flight" response

Systole—the phase of the cardiac cycle in which the heart's ventricles are actively contracting and pumping blood, at which time the pressure against the arteries is at its highest

T-wave—a wave on an ECG representing the recovery period of the ventricles

Tachycardia—a heartbeat that exceeds 100 beats per minute

TASER®—the proprietary name commonly used to refer to a conducted energy weapon

Triangulate—a means to locate a point by measuring angles to it from two or more other known points

Troponins—regulatory proteins involved in the contraction of cardiac and skeletal muscles. They are released into the bloodstream when cardiac cells die. An elevated level indicates muscle damage.

Transdiaphragmatic positioning—positioning across the diaphragm

Ventricular capture—the capture of an electrical impulse by the ventricles, which may cause the ventricles to contract

Ventricular defibrillation—a treatment used to normalize the heartbeat by introducing an electrical shock to the ventricles of the heart

Ventricular fibrillation—a condition in which there is uncoordinated and abnormal contraction of the muscles of the ventricles of the heart

Ventricular tachycardia—a rapid heartbeat emanating from one or both of the ventricles of the heart

Vitreous electrolytes—naturally occurring chemicals associated with the vitreous of the eye

Volitional resistance—resistance that is voluntary